PATIENT INFORMATION

FULL NAME_____BIRTH DATE _____ AGE _____ F / M

ADDRESS_____CITY/STATE_____ZIP_____

SOCIAL SECURITY NO._____HOME PHONE_____ MARITAL STATUS: S M D W

E-MAIL ADDRESS_____CELL PHONE _____

Please send email updates & cost saving specials on treatments offered here YES / NO *Please text appointment reminders* YES / NO

EMPLOYER_____WORK PHONE _____

RESPONSIBLE PARTY_____ PHONE _____

ADDRESS (IF DIFFERENT FROM ABOVE_____

NAME OF SPOUSE OR PARENT _____PHONE_____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

EMERGENCY CONTACT _____PHONE_____ALT PHONE _____

PRIMARY INSURANCE_____SECONDARY INSURANCE_____

WHO REFERRED YOU TO THIS OFFICE? _____

MEDICAL HISTORY

PRIMARY CARE DOCTOR_____PHONE_____

ADDRESS_____FAX_____

EYE CARE DOCTOR _____OD___MD_____ PHONE_____

ADDRESS_____FAX_____

CARDIOLOGIST_____PHONE_____

ADDRESS_____FAX_____

SPECIALIST_____PHONE_____

SPECIALTY/ADDRESS_____FAX_____

HAVE YOU EVER HAD AN EYE INJURY OR EYE SURGERY? Y / N IF SO, PLEASE EXPLAIN_____

DO YOU CURRENTLY OR HAVE YOU EVER HAD A SERIOUS ILLNESS OR INJURY? Y / N IF SO, PLEASE EXPLAIN_____

_____

PLEASE LIST ALL MEDICATION, VITAMINS, AND OVER THE COUNTER MEDS YOU CURRENTLY TAKE AND TAKE OCCASIONALLY:

_____ _____ _____

_____ _____ _____

_____ _____ _____

(If additional space is needed, please use the back of this form)

ARE YOU ALLERGIC TO ANY MEDICATION? Y / N IF SO, PLEASE LIST_____

DO YOU TAKE? Aspirin Y / N Blood Thinners Y / N Name of Med_____

Anti-inflammatory Y / N Name of Med _____

FAMILY HISTORY

DO YOU HAVE A ***FAMILY HISTORY*** OF? CATARACT Y / N GLAUCOMA Y / N SKIN CANCER Y / N

_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION AND MEDICAL OR LEGAL REPORTS NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE COMPANY TO MAKE DIRECT PAYMENTS TO THE PHYSICIAN.

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_____ _____

SIGNATURE **DATE**

***MUST BE SIGNED IN ORDER FOR US TO BILL YOUR INSURANCE COMPANY**