Patient's name First_____Last_____ Today's date _____

Preferred name/nickname _____ ☐ Male ☐ Female Date of birth _____

Street address _____

City _____ State _____ Zip _____

Cell phone _____ Email address _____
Okay to text? ☐ yes ☐ no Okay to email? ☐ yes ☐ no

Home phone _____ Work phone _____ Last 4 of patient's SS# _____

Occupation _____ Spouse's name _____

Parents (if patient is a student) This section can also be used for anyone who makes medical or financial decisions for the patient, regardless of patient's age.

Name _____ Preferred phone # _____

Name _____ Preferred phone # _____

Primary Vision Insurance _____ Member SS# _____

Member Name_____ Member DOB _____

YES	NO	
☐	☐	Do you have glasses?
☐	☐	Do you wear contact lenses?
☐	☐	Wish to continue wearing contacts?
☐	☐	Wish to try contacts for the first time?
☐	☐	Have you ever had eye surgery?
☐	☐	Have you ever had an eye injury?
☐	☐	Have you previously been diagnosed with an eye disease?

List any medications: (If you have a written list, we can copy it instead.)

_____

_____

_____

_____

Medication allergies:_____

Check any condition you have
OR for which you are receiving treatment

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Heart/cardiovascular disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Currently pregnant
- ☐ Thyroid disorder
- ☐ Other health issue(s):

_____

Is there any history in your family of:
(include parents, grandparents, and siblings only)

- ☐ **NONE**
- ☐ UNKNOWN
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Other eye disease:

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.

I authorize the use of this form on all my insurance submissions. I authorize release of information too all of my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.

SIGNATURE: DATE: