PLEASE PRINT CLEARLY: Date:_____

Patient name:_____Occupation:_____

Address:_____ ZipCode:_____

Date of Birth:_____Home/Cell #:_____Work/Cell#:_____

E- Mail:_____Referred By:_____

- Do you have **VISION** insurance? Y or N (if NO please sign at the bottom and return to desk)

Primary Insurance Company:_____ Last 4 of Insured SSN:_____

Policy Holder Name:_____Relationship to Patient:(Self)(Spouse)(Parent)___

Policy or Identification Number:_____Group Number: _____

Policy Holder Date of Birth:_____Employer's Name:_____

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- Is there a Secondary or **MEDICAL** Insurance Plan? Y or N

Insurance Company:_____ (Secondary) or (Medical)

Address/City/State Zip:_____

Policy Number: _____Group Number: _____

I authorize the release of medical records to process this claim and payment to the undersigned

Provider: Yes_____ No_____ Signature_____

I agree to pay for the additional charges that my insurance plan does not cover for professional services and glasses or contact lens purchases.

Signed:_____Date:_____

Privacy Practices Acknowledgement

I have received the notice of privacy practices and I have been provided an opportunity to review it (*Please see Attached*)

Name (if not the Patient):_____Date of Birth:_____

Signature:_____Date:_____

Reason For Visit:_____ **Last Eye Exam:**_____

Present Eye/Vision Conditions: (Please circle all that apply) **Location:** Both Eyes, Rt. Eye, Left Eye **Quality:** Bothersome, Awareness, Painful **Severity:** Severe, mild, moderate **Duration:**_____ **Timing:** new condition, previous or ongoing **Context:** assoc. with injury, infection, surgery, or medical condition **Mod Factors:** Treated by another provider, Taking medication, Taking drops **Assoc Signs:** Tearing, Double Vision, Mattering, Pain, Loss of vision, Photophobia, Itching, Headache, Flashes, Burning, Red, Floaters, Blurred Vision

ARE YOU INTERESTED IN TRYING CONTACTS OR DISCUSSING YOUR CONTACT LENS OPTIONS? Y N

Review of Systems: (Please circle all that apply) **Family Physician:** _____

Constitution: Fatigue Syndrome, Developmental Disabilities, Cancer, _____

ENT: Sinusitis, Laryngitis, Hearing Loss, Dry Mouth, _____

Neurology: Multiple Sclerosis, Tumor, Cerebral Palsy, Stroke/CVA, Migraine, Epilepsy,_____

Psychiatry: Bipolar Disorder, Depression, Anxiety Disorder, Attention Deficit, _____

Cardiovascular: Stroke/CVA, Negative, Congestive Heart Failure, Vascular Disease, Heart Disease, Hypertension, _____

Respiratory: Asthma, Bronchitis, Chronic Obstruction, Cigarette Smoker, Sleep Apnea, Emphysema, _____

GI: Acid Reflux, Crohn's, Ulcer, Celiac Disease, Colitis, _____

GU: Herpes, STD, Kidney disease, Nursing, Chlamydia, Prostate disease/cancer, Benign Prostate Hypertrophy, Pregnant, _____

Musc/Skel: Fibromyalgia, Gout, Arthritis, Ankylosing Spondylitis, Osteoarthritis, Muscular Dystrophy, Osteoporosis, _____

Integ: Eczema, Psoriasis, Herpes Zoster/Shingles, Herpes Simplex/Cold Sores, Rosacea, _____

Endocrine: Type 2 Diabetes Mellitus, Thyroid dysfunction, Type 1 Diabetes Mellitus, Hormonal Dysfunction , _____

Hem/Lymph: Ulcer, Large-volume blood loss, Cholesterol , Anemia, _____

Allergy/Immun: Rheumatoid Arthritis, Sjogren's Syndrome, Environmental Allergies, Lupus, Drug Allergies, _____

Current Medications: 1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____ 7)_____

Medication Allergies: _____ **Other Allergies:** _____

Ocular History:	Self	Family Member		Self	Family Member
Macular Degeneration	____	_____	Cataract	____	_____
Glaucoma/Glauc. Suspect	____	_____	Amblyopia/Lazy Eye	____	_____
Retinal Detachment	____	_____	Dry Eyes	____	_____
Eye Surgery:_____	____	_____	Other: _____		

Social History: **Smoking Habits:** **Y** **N** **Drinking Habits:** **Y** **N**

Additional Comments: _____