

PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 DATE OF LAST EXAM \_\_\_\_\_ REFERRED BY \_\_\_\_\_ MEDICARE # \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 NAME OF PARENT OR SPOUSE \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_ (for insurance verification)

**HEALTH INFORMATION:**

Reason for this visit: \_\_\_\_\_ routine exam for glasses \_\_\_\_\_ routine exam for glasses and contacts.  
 \_\_\_\_\_ eye infection \_\_\_\_\_ eye injury  
 \_\_\_\_\_ other \_\_\_\_\_

Have you ever had a injury or surgery to your eyes? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

Last physical exam \_\_\_\_\_ Dr. \_\_\_\_\_ Any abnormalities reported  
 from this exam? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

Are you presently taking hormones? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ List any medications  
 you may be currently taking \_\_\_\_\_

**HEALTH HISTORY:** (Please check all that apply)

	You	Blood Relative		You	Blood Relative
Glaucoma	_____	_____	Diabetes	_____	_____
Cataracts	_____	_____	High Blood Pres.	_____	_____
Lazy Eyes	_____	_____	Low Blood Pres.	_____	_____
Blindness	_____	_____	Heart Disorder	_____	_____
Allergies	_____	_____	Thyroid Disorder	_____	_____
Color Blindness	_____	_____	Cancer/Tumors	_____	_____
Intestinal/Digestive/Disorder	_____	_____	Retinal Disorder	_____	_____
Kidney/Liver Disorder	_____	_____	Asthma/Bronchitis	_____	_____
Arthritis	_____	_____	High/Low Blood Sugar	_____	_____
Fainting/Dizziness	_____	_____	Other	_____	_____

**FULL PAYMENT IS REQUIRED AT TIME OF SERVICE / PLEASE DISCUSS YOUR INSURANCE PLAN WITH OFFICE STAFF BEFORE EXAMINATION**

**WE ACCEPT THE FOLLOWING FORMS OF PAYMENT. PLEASE INDICATE BELOW HOW YOU INTEND TO PAY:**

Cash \_\_\_\_\_ Check \_\_\_\_\_ Charge \_\_\_\_\_ (There is a \$20.00 charge on all returned checks and we do require a valid driver's license.)