

**PATIENT DATA** PLEASE PRINT

PATIENT'S LEGAL NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ INITIAL \_\_\_\_\_  
 MALE  FEMALE  SINGLE  MARRIED  DIVORCED  WIDOWED EMAIL: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_ ALTERNATE PHONE: (\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_\_  
SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S WORK PHONE: (\_\_\_\_) \_\_\_\_\_  
PATIENT'S ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_  
TYPE OF INSURANCE: \_\_\_\_\_  
I.D. NUMBER \_\_\_\_\_ GROUP: \_\_\_\_\_ SERVICE CODE: \_\_\_\_\_  
OTHER MEDICAL INSURANCE: \_\_\_\_\_  
MEDICARE NUMBER: \_\_\_\_\_

**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)**

NAME: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_  
ADDRESS (if different than patient): \_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMPLOYED BY: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
TYPE OF INSURANCE: \_\_\_\_\_  
I.D. NUMBER \_\_\_\_\_ GROUP: \_\_\_\_\_ SERVICE CODE: \_\_\_\_\_

**REFERRED BY**

HOW DID YOU HEAR ABOUT US: \_\_\_\_\_  
REFERRED BY DOCTOR: \_\_\_\_\_ FRIEND/RELATIVE: \_\_\_\_\_  
NEWSPAPER AD; \_\_\_\_\_ TV AD: \_\_\_\_\_ RADIO AD: \_\_\_\_\_  
ESTABLISHED PATIENT: \_\_\_\_\_  
OTHER: \_\_\_\_\_

**IN CASE OF EMERGENCY**

NAME OF RELATIVE OR FRIEND AT A DIFFERENT ADDRESS: (In case we cannot reach you.)

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

# MEDICAL

# PLEASE ANSWER ALL MEDICAL QUESTIONS

ARE YOU PRESENTLY EXPERIENCING EYE PROBLEMS?  YES  NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

HAVE YOU EXPERIENCED EYE PROBLEMS IN THE PAST?  YES  NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

HAS ANYONE IN YOUR FAMILY HAD:  CATARACTS \_\_\_\_\_ Relationship  GLAUCOMA \_\_\_\_\_ Relationship  
 NONE  DIABETES \_\_\_\_\_ Relationship  HYPERTENSION \_\_\_\_\_ Relationship

DURING THE PAST YEAR, HAVE YOU BEEN UNDER A PHYSICIAN'S CARE:  YES  NO  
IF YES, EXPLAIN: \_\_\_\_\_

PLEASE ANSWER ALL OF THE FOLLOWING:

SERIOUS ILLNESS  NO  YES (Describe) \_\_\_\_\_

MAJOR OPERATION  NO  YES (Describe) \_\_\_\_\_

HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/> NO <input type="checkbox"/> YES	ARTHRITIS	<input type="checkbox"/> NO <input type="checkbox"/> YES	KIDNEY/BLADDER TROUBLE	<input type="checkbox"/> NO <input type="checkbox"/> YES
BLEEDING PROBLEMS	<input type="checkbox"/> NO <input type="checkbox"/> YES	ULCERS	<input type="checkbox"/> NO <input type="checkbox"/> YES	SINUS TROUBLE	<input type="checkbox"/> NO <input type="checkbox"/> YES
HEART DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES	PACEMAKER	<input type="checkbox"/> NO <input type="checkbox"/> YES	X-RAY THERAPY	<input type="checkbox"/> NO <input type="checkbox"/> YES
HEPATITIS/ LIVER TROUBLE	<input type="checkbox"/> NO <input type="checkbox"/> YES	STROKE	<input type="checkbox"/> NO <input type="checkbox"/> YES	HEADACHE FREQUENT/SEVERE	<input type="checkbox"/> NO <input type="checkbox"/> YES
PSYCHIATRIC TREATMENT	<input type="checkbox"/> NO <input type="checkbox"/> YES	DIABETES	<input type="checkbox"/> NO <input type="checkbox"/> YES	THYROID	<input type="checkbox"/> NO <input type="checkbox"/> YES
CORTISONE, HYDROCORTISONE	<input type="checkbox"/> NO <input type="checkbox"/> YES	HERPES/SHINGLES	<input type="checkbox"/> NO <input type="checkbox"/> YES	HIV POSITIVE/AIDS	<input type="checkbox"/> NO <input type="checkbox"/> YES
ASTHMA	<input type="checkbox"/> NO <input type="checkbox"/> YES				
ARE YOU PREGNANT?	<input type="checkbox"/> NO <input type="checkbox"/> YES		OTHER _____		

LIST ALL EYE DROPS CURRENTLY USING: \_\_\_\_\_

LIST ALL MEDICATIONS, PILLS CURRENTLY USING: \_\_\_\_\_

LIST ALLERGIES:  NONE  PENICILLIN  ASPIRIN  CODEINE  SULFA  OTHER \_\_\_\_\_

WHEN WAS THE LAST TIME YOU RECEIVED A NEW PRESCRIPTION FOR YOUR GLASSES?: \_\_\_\_\_

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. ALL UNPAID BALANCES WILL BE CHARGED INTEREST AT 1 1/2% PER MONTH AFTER 30 DAYS.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND AUTHORIZE YOU TO BILL MY INSURANCE.

PATIENT SIGNATURE: \_\_\_\_\_  
(OR PARENT OR GUARDIAN'S SIGNATURE IF PATIENT IS A MINOR)

DATE: \_\_\_\_\_