Welcome to Our Office!

Patient's Name (please circle one Dr./Mr./Mrs./Ms.) _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

Home Phone # ( ) _____ Work # ( ) _____ Cell # ( ) _____

E-mail (optional) _____

Occupation _____ Employer _____

Who is responsible for this account? _____ Relationship to patient _____

Primary Insurance Co.: _____ ID# / SS#: _____ Member Date of Birth: _____

Secondary Insurance Co.: _____ ID# / SS#: _____ Relationship to patient _____

Medical Insurance: _____ ID# / SS#: _____ Relationship to patient _____

Please present all insurance cards to the receptionist.

Primary Care Doctor _____ Doctor's Phone Number _____

Reason for today's exam _____

How did you hear about our practice?

- ☐ former patient
- ☐ family comes here
- ☐ referred by another patient _____ (name)
- ☐ phone book
- ☐ insurance company
- ☐ referred by doctor
- ☐ location
- ☐ newspaper
- ☐ website (VSP.com / YellowPages.com / SmartPages.com)

Do you currently wear glasses? ☐ Yes ☐ No ☐ Reading only ☐ Distance only

Have you ever worn contact lenses before? ☐ Yes ☐ No Type? _____

Do you wear contact lenses during sleep? ☐ Yes ☐ No

Are you interested in any of the following? ☐ Contact lens wear ☐ LASIK surgery

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Do you use a computer? ☐ Yes ☐ No Hobbies: _____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No ☐ Special occasions only

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Eye History (Please check all boxes that apply to YOU)

- ☐ Sandy, Gritty, or Foreign Body Sensation
- ☐ Burning / Stinging / Itching
- ☐ Flashes / Floaters
- ☐ Eye Surgery / Eye Injury
- ☐ Glaucoma Other: _____

Do your family/relatives have any of the following?

- ☐ Glaucoma
- ☐ Diabetes
- ☐ Macular Degeneration
- ☐ Heart Disease
- ☐ Blindness
- ☐ Tuberculosis
- ☐ Lazy Eye
- ☐ Other _____

Health History (please check all boxes and circle conditions that apply to YOU)

- ☐ High Blood Pressure
- ☐ Diabetes or Thyroid Condition
- ☐ Heart Disease
- ☐ High Cholesterol or Anemia
- ☐ Allergies, Lupus, Sjogren's Syndrome
- ☐ Asthma or Emphysema
- ☐ Arthritis
- ☐ Skin
- ☐ Neurological (Multiple Sclerosis, etc.)
- ☐ Gastrointestional (Ulcer, etc.)
- ☐ Genital, Kidney, or Bladder
- ☐ Sinus Trouble, Ear Infection, or Chronic Cough

Current Medications: _____

_____

Allergies to Medications: _____

OFFICE POLICY

Services & materials payment (including co-payments) is expected at the time services are rendered unless prior arrangements have been made.

AUTHORIZATION

I certify that I have read and answered the above questions to the best of my knowledge.
I authorize the eye doctor to release any information of treatment rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize my insurance company to pay directly to the eye doctor, benefits payable to me.
I agree to be responsible for payment of all services rendered on my behave or my dependents.

Signed _____ Date _____