

Name _____

Address _____

Phone-Home _____

Phone-Work _____

Phone-Cell _____

Occupation _____

Email _____

Sex M F Marital Status M S D W

Age _____ Date of Birth _____

SS# _____

Referred By _____

INSURANCE INFORMATION

What is your primary medical insurance?

Insurance name _____

Subscriber _____

Relationship to patient _____

ID# _____

Copay _____ Referral needed? _____

What is your secondary medical insurance?

Insurance name _____

Subscriber _____

Relationship to patient _____

ID# _____

Copay _____ Referral needed? _____

Do you have vision/eyeglass/contact lens coverage?

Plan name _____

Subscriber _____

Relationship to patient _____

ID# _____

Please give us your insurance cards so we may make copies for your chart.

MEDICAL HISTORY

Have you been diagnosed with high blood pressure? Yes No
If yes, what year? _____ Name of medicine _____

Have you been diagnosed with diabetes? Yes No
If yes, what year? _____ Name of medicine _____

Have you been diagnosed with high cholesterol? Yes No
If yes, what year? _____ Name of medicine _____
OR diet/exercise controlled

Please list any other medications, vitamins, allergy pills or dry eye treatments (artificial tears/gels) that you take on a daily basis _____

Any other medical problems?

Please list any allergies you have:

To Medicine: _____

SEASONAL: _____

Have you ever had any eye diseases, eye injuries, eye surgery (including refractive surgery) or problems with your eyes? Please describe.

Is there a family history of glaucoma, diabetes, high blood pressure or another disease that runs in your family? Please list _____

SIGNATURE ON FILE

I authorize the doctor to use this authorization instead of my actual signature on my insurance submissions. I authorize the release of information to my insurance companies. I authorize payment directly to my doctor, when applicable. I understand I am responsible for my bill for any non-covered services. I have received a copy of the office HIPAA

Signature _____

Relationship, if not patient _____

Date _____

Reviewed by _____ No change _____ Date _____

Reviewed by _____ No change _____ Date _____

Reviewed by _____ No change _____ Date _____