## Patient Information

Name: ______________________________ DOB: _______________ SS#:________________________

Address:______________________________ City: ______________ State: _____ Zip Code: _________

Home Phone#: ____________________________ Cell Phone#: __________________________________

Email address: _________________________________ Preferred Method of Contact: ________________

Primary Care Provider: ______________________________ Office Phone# :_________________________

## Referral Information- How did you find us? *(circle the one that applies)*

| | | |
|---|---|---|
| Referred by your doctor | Facebook | TV commercial |
| Family | Google search | Live in the neighborhood |
| Friend | Insurance List | Other |

## Primary Insurance

Insurance Name: ___________________________

Policy ID#:________________________________

Group #: __________________________________

Policy holder's Name: _______________________

DOB: ____________SS#:_____________________

## Secondary Insurance

Insurance Name: ___________________________

Policy ID#:________________________________

Group #: __________________________________

Policy holder's Name: _________________________

DOB: ____________SS#:_____________________

## Financial Assignment Information

## Acknowledgment of Notice of Privacy Practices (NPP)

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature: _____________________________________________________ Date: ___________________________

Are you currently taking any medications? If so, please list below. (Attach sheet if more space is needed)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

## Vision Correction History *(please circle all that apply)*

Amblyopia
Blurred vision at a distance
Blurred vision at near
Burning
Double vision
Drooping eyelid(s)
Dryness
Eye pain and/or soreness
Floaters or spots
Fluctuating vision
Foreign body sensation
Halos
I experience regular headaches
I stopped wearing contact lenses
I stopped wearing glasses
Infection of eye or lid
Itching
Loss of peripheral vision
Loss of vision
Mucous discharge
Redness
Sandy or gritty feeling
Sensitivity to light/glare
Strabismus (crossed eye)
Tired eyes
Watery eyes

## Family History *(please circle all that apply)*

Cancer
Diabetes
Hypertension (high blood pressure)
Hyperthyroidism
Hypothyroidism
Cataracts
Macular Degeneration
Glaucoma

## General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? _______________

Do you have any of the following? *(please circle all that apply)*

Acid reflux
Allergies
Anxiety disorder
Arthritis
Asthma
Attention deficit
Bipolar disorder
Cancer
Celiac disease
Congestive heart failure (CHF)
COPD
Depression
Diabetes
Emphysema
Hearing loss
Heart disease
High cholesterol
Hypertension (high blood pressure)
Lupus
Migraines
Multiple sclerosis
Stroke/CVA
Thyroid disfunction