WELCOME TO OUR OFFICE

Patient's Name: ______________________________ Date: __________

Address: ______________________________ City: __________ Zip: ______

Home Telephone: ______________________________

Person Responsible for Bill: ______________________________

Address: ______________________________ City: __________ Zip: ______

Whom may we thank for referring you to this office? ______________________________

Family______ Friend______ Phone book______ Other, explain ______________

S.S.# ______________________ Date of birth ______________________

Employer ______________________________ Telephone __________

Employer address ______________________ City __________ Zip ______

Please check the method of payment for today's professional services:

______Cash ______Check ______Credit Card ______Insurance ______________

Insurance Coverage:

For Vision Care - Insurance Co. ______________________________

Group #______________________ Member______________

For Major Medical - Insurance Co. ______________________________

Group#______________________ Member______________

Subscriber Name ______________________________

Patient or parents signature ______________________________

MEDICAL HISTORY

Do you have any of the following conditions?

Yes____ No____ Allergies?

Yes____ No____ Diabetes?

Yes____ No____ Drug sensitivities?

Yes____ No____ High blood pressure?

Yes____ No____ Heart disease?

Yes____ No____ Eye or head injuries?

Yes____ No____ Seizures?

Yes____ No____ Thyroid problems?

Yes____ No____ Other?

Are you under care for any disease or condition at this time? Yes____ No____

Are you currently taking any drugs or medications? Yes____ No____

Do you use cigarettes, alcohol or other substances? Yes____ No____

____

____

(over)

EYE HEALTH HISTORY

Reason for examination: ____________________

Have you ever had any of the following conditions?

Yes____ No____ Eye treatment, medication, surgery, injury?

Yes____ No____ Periods of seeing double?

Yes____ No____ Sudden loss of vision?

Yes____ No____ Flashes of light?

Yes____ No____ Floating black spots?

Yes____ No____ Pain in your eyes?

Yes____ No____ Difficulty seeing at night?

Yes____ No____ Itching, tearing, burning, secretions, styes?

Yes____ No____ Sensitivity to light?

Yes____ No____ Frequent headaches or migraines?

Yes____ No____ Do you tire quickly when reading?

Yes____ No____ Do you squint your eyes to see clearly?

Yes____ No____ Trouble making depth and distance judgments?

Yes____ No____ Family history of eye disease or blindness?

Do you wear glasses or contact lenses now? ____________________

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In order to control our cost of billing we request that office visits be paid at the time that service is rendered. We would rather control our billing costs than be forced to raise our fees.

Thank you.

It is agreed that payment of this bill is the responsibility of the patient. Failure of the insurance company to pay shall not relieve the patient of this liability.

In the event that the above described bill is not paid within 60 days of this date, interest will run on the unpaid balance at the rate of one (1) percent per month but in no event more than the maximum rate allowed by law. Should legal action be instituted to collect this bill, the patient agrees to pay reasonable attorney's fees and all collection costs.

Dated:____________________ ____________________

Patient's Signature

Signature below is only acknowledgement that you have read our HIPPA notice of privacy practice:

Print Name:____________________ Signature:____________________ Date____________