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 (includine refactive 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_____