

PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number (Area Code): (_____) _____

E-mail Address: _____

Please circle one: Male Female Marital Status: Single Married Divorced Widow

Social Security Number: _____ Occupation: _____

Employer Name: _____ Employer Phone: _____

What kind of work do you currently do or have done in the past: _____

Who referred you to our office?: _____

Name and number of friend or relative in case of emergency: _____

Family Doctor: _____

INSURANCE INFORMATION

Primary Insurance Company (example MEDICARE): _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____

Secondary Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____

Some services are NON-COVERED by insurance companies, therefore, we ask for payment at the time of service. For example: Refraction's, Co-Pays and Deductibles.

***Account going beyond 90 days past due will incur a \$30.00 collection fee.

ASSIGNMENT: I hereby assign payment of surgical and/or medical benefits, otherwise payable to me for the services described above, and also release of medical information.

Signature: _____ Date: _____

Thank You.

GENERAL MEDICAL INFORMATION

Reason for visit: _____

Date of last eye exam: _____

List all Drug Allergies: _____

LIST ALL MEDICATIONS YOU CURRENTLY TAKE: _____

List all major illnesses and injuries: _____

List recent hospitalizations and what they were for: _____

Do you drive? Yes No

Do you have difficulty seeing while driving? Yes No

Is license renewal needed? Yes No

Do you have a problem with night vision? Yes No

Do you currently wear glasses? Yes No

How old is your last Rx? _____

Do you currently wear contact lenses? Yes No

Have you or your immediate family members had any of the following:

	YOU	FAMILY MEMBER (Relationship)
Blindness	_____	_____
Cataract	_____	_____
Glaucoma	_____	_____
Macular degeneration	_____	_____
Retinal detachment	_____	_____
Arthritis	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Heart Attack	_____	_____
High Blood Pressure	_____	_____
Kidney Disease	_____	_____
Lupus	_____	_____
Sjogrens Syndrome	_____	_____
Stroke	_____	_____
Thyroid Disease	_____	_____
Tuberculosis	_____	_____
Other (please list)	_____	_____
