Today's Date..... Male/Female (Please Circle)
Last Name..... First Name..... MI.....
Address..... City..... State..... Zip.....
Home Phone..... Work Phone..... Other.....
Date of Birth..... SSN.....
Employer..... Occupation.....
Parent/Guardian's Name (If Patient is a Minor).....
Who may we contact in case of an emergence? Name..... Phone.....

PERSONAL EYE INFORMATION

Date of Last Eye Exam..... Were your eyes dilated at that time? Y / N / Unknown
Do you wear glasses? Y/N Do you wear contact lenses? Y/N
Do you have; Glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred vision? Y/N
Have you had any eye operations? Y/N Type..... Date.....
Have you had an eye injury Y/N Kind..... Date.....
Additional Information.....

MEDICAL INFORMATION

How is you general health?.....
Do you have problems with any of these systems?

Gastrointestinal	Y/N	nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/Lymph	Y/N
				Allergic/Immunologic	Y/N

Please explain.....
Do you have Diabetes? Y/N Type..... Date of diagnosis.....
Do you have headaches Y/N please explain.....
Other health problems.....
Are you allergic to any medications? Y/N please list.....
.....
Are you taking any prescription medications? Y/N please list.....
.....
Have you had any operations? Y/N Kind..... Date.....
Date of last tetanus shot.....
Name of family doctor.....
Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substances? Y/N

FAMILY HISTORY

High blood pressure	Y/N	Relation.....	Macular degeneration	Y/N	Relation.....
Diabetes	Y/N	Relation.....	Retinal detachment	Y/N	Relation.....
Glaucoma	Y/N	Relation.....	Cataracts	Y/N	Relation.....
Other eye or health conditions?		Y/N Kind.....			Relation.....

Who may we thank for referring you?.....

Our office will gladly complete your insurance claim for you. However, we can not guarantee that this will ensure payment form your carrier. Any unpaid portion of you account will be your responsibility. Patient will be responsible for all reasonable attorney and court costs if the account is turned over for collection proceedings.

_____
I have read and understand the above.