Welcome to our Office
Please Print

Name: _____ Date of Birth: _____
Address: _____
City, State, Zip code: _____
Primary Phone: _____ Secondary Phone: _____
Email: _____
Employer: _____ Occupation: _____
Vision Insurance: _____ Membership ID: _____
Date of last vision exam: _____ Primary Care Doctor: _____

Reason for today's visit (Mark all that apply.)

___ General Check Up
___ Wants new glasses
___ Blurred distance vision
___ blurred near vision
___ Eyes water, itch burn, etc.
___ Wants Contact lenses
___ Flashes and Floaters
___ Other_____

Do you or any family member have a history of: (Mark 'X' for you and 'F' for family.)

___ High blood pressure
___ Diabetes
___ High cholesterol
___ Cancer
___ Heart disease
___ Asthma/allergies
___ Glaucoma
___ Cataracts
___ Loss of vision/blindness
___ Eye/head injury
___ Eye surgery
___ Other_____

Present Medications: _____
_____

Allergies to medications and Food: _____

I acknowledge and agree that I have received a copy of the Notice of Privacy Practices (HIPAA) for review and to keep for my records on the date identified below. I request that payment of authorized insurance benefits be made on my behalf for any services furnished to me by these physicians/suppliers. I understand that if for any reason insurance does not cover my charges I will be financially responsible for payment.

Signature: _____ Date: _____

Update History/HIPAA Signature: _____ Date: _____

Update History/HIPPA Signature: _____ Date: _____

Update History/HIPAA Signature: _____ Date: _____

Update History/HIPAA Signature: _____ Date: _____

Update History/HIPAA Signature: _____ Date: _____