Patient Name _____

Date of Birth _____Male ☐ Female☐ SSN # _____

Address _____

City _____State _____Zip _____

Telephone #'s: Home _____Work _____Cell _____

Routine vision care insurance _____

ID# _____

Please provide medical insurance information to be billed if you do not have a routine vision care policy or for any services or testing that is not covered under the scope of a routine exam. (Photo's, eye injury, etc.)

Primary Insurance Information

Carrier _____ID# _____

Name of Policy Holder _____

Secondary Insurance Information

Carrier _____ID# _____

Name of Policy Holder _____

I have provided the information above for the purpose of billing the services I will receive today. By signing this form I guarantee this information is correct. I understand that I am responsible for any balances not paid by these or any other insurances I have not provided to you within a timely manner. I understand that any benefits information provided to you by my insurance is not a guarantee of payment. Only after the insurance has paid can a final determination of charges be made.

Signature _____ Date _____

Medical Information

Have you recently noticed any of the following?

☐ Blur at distance
☐ Blur at near
☐ Eye strain
☐ Double vision
☐ Flashes of light
☐ Pain in or around the eyes
☐ Headaches
☐ Spots floating
☐ Bright lights bothering eyes
☐ Other Symptoms (list)_____

Have you or anyone in your family (now or in the past) ever had:

Self	Family		Self	Family	
☐	☐	Glaucoma	☐	☐	Strabismus (crossed eyes)
☐	☐	Eye Surgery	☐	☐	Blindness
☐	☐	Cataracts	☐	☐	Myopic (nearsightedness)
☐	☐	Eye or Head Injuries	☐	☐	Hyperopic (farsightedness)
☐	☐	Other (list)_____			

Have you or anyone in your family (now or in the past) ever had:

Self	Family		Self	Family	
☐	☐	High Blood Pressure	☐	☐	Allergies
☐	☐	Heart Disease	☐	☐	Sinus Problems
☐	☐	Diabetes	☐	☐	Thyroid Disease
☐	☐	Other (list)_____			

List Current Medications_____

_____

_____

List activities_____

Approximate date of your last general health exam_____

Approximate date of your last eye exam_____

Do you wear ☐ glasses and/or contacts☐? If so, do you were them for:
☐ Near ☐ Distance only ☐ Work ☐ As Needed ☐ Full Time

Would you like to ask about contact lenses or specialty eyewear?_____