FOR INTERNAL USE ONLY Billed:_____

Dx Code(s): A. _____B. _____C. _____

_____

DATE: _____

NAME: _____

DATE OF BIRTH: _____ AGE_____

RES. ADDRESS:_____ RES. PHONE/CELL: _____

EMPLOYED BY: _____ BUS. PHONE:_____

OCCUPATION: _____ EMAIL: _____

SPOUSE/PARTNER NAME: _____

PRIMARY CARE PHYSICIAN: _____ PCP PH#:_____

SUBSCRIBER NAME/ID: _____

INSURANCE NAME AND POLICY NUMBER: _____

SUBSCRIBER NAME/ID: _____

INSURANCE NAME AND POLICY NUMBER: _____

Do you have any history of the following?

☐ High Blood Pressure ☐ Tuberculosis ☐ Heart Trouble ☐ Ear Troubles ☐ Glaucoma

☐ Rheumatic Fever ☐ Diabetes ☐ Blood Disease ☐ Kidney/Liver Involvement ☐ Eye Disorder

☐ Cancer ☐ Anemia ☐ Arthritis ☐ Strabismus/Amblyopia (Turned or Lazy Eye)

☐ Head Injury ☐ Asthma ☐ Other _____

Has anyone in your family had the following?

☐ High Blood Pressure ☐ Eye Disease ☐ Heart Disease ☐ Blindness ☐ Strabismus (Turned Eye)

Are you sensitive or allergic to any medications? ☐No ☐Yes; If yes, please name _____

Are you under a doctor's care? ☐No ☐Yes; If yes, why?_____

Are you taking any medications now? ☐No ☐Yes; If yes, for what purposes? _____

Please list the medications: _____

Are you taking any hormones, including Birth Control Pills? ☐No ☐Yes

Have you ever worn contact lens? ☐No ☐Yes; If yes, which brand? _____

If you use contact lenses which cleansing solution do you use? _____

Any surgeries? Eye injury/ disease? Head trauma? _____

Date of Last Exam: _____ By Whom: _____

Whom may we thank for referring you? _____

While we will make every effort to verify and confirm your insurance, it is your responsibility to understand all conditions of your insurance plan.

I was shown and understand the privacy policy (HIPAA). _____

PLEASE SIGN ON ABOVE LINE