Patient Information Today's Date__________

Last name____________________________ First name____________________________ MI_____
Address________________________________ City___________________ State ____ Zip______
Home phone_________________ Work phone_______________ Cell phone___________________
Which is the best phone number to contact you? *(circle one)* Home Work Cell
Date of Birth___/___/____ Social Security # ____-____-_____ CA Driver's License #_____________
Occupation ______________________________ Employer__________________________________
Spouse's Name ___________________________ Employer__________________________________
Referred By ___________________________
Email address ____

Note: We use your email address to notify you when your glasses and/or contacts are ready for pick-up, when you are due for an annual exam, and to send quarterly newsletters. You may opt out at any time.

Insurance Information

Primary Vision Coverage__________________________________
Secondary Coverage_____________________________________
Medical Insurance _______________________________________

Subscribers Information *(if not patient)*
Name____ Date of Birth___/___/____
SSN or Insurance ID #_________________ Relationship to Patient__________________

Medical History

How is your general health?____
Do you take medications for any of these systems? *(circle Yes or No)*

Gastrointestinal	Y/N	Nervous	Y/N	Endocrine	Y/N
Ears/Nose/Throat	Y/N	Urinary	Y/N	Blood/Lymph	Y/N
Cardiovascular	Y/N	Respiratory	Y/N	Allergic/Immunologic	Y/N
Muscles/Bones	Y/N	Skin	Y/N	Headaches	Y/N
Mental	Y/N	Eyes	Y/N	High Blood Pressure	Y/N

Please explain____
Diabetes Y/N Type_____________________ Date of Diagnosis_____________
Allergies to Medication Y/N Which?________________________ Reactions?__________________
Other Health Problems____
Current Medications____
Have you had any operations? Y/N Kind?_____________________________ Date _______________
Primary Care Physician_________________________________ Date of Last Visit__________________
Date your blood pressure was last checked ___________________
Are you a smoker? *(check one)* Now_____ Previously_____ Never______

-OVER-

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_______________

Personal Eye Information

Date of Last Eye Exam________________ Dilated? Y/N
Do you have any eye conditions or problems? Y/N Kind? ________________________________
Have you had any eye operations? Y/N Kind?____________________ Date______________
Have you had an eye injury? Y/N Kind? ______________________________ Date______________
Do you have glaucoma? Y/N
Cataracts? Y/N
Macular Degeneration? Y/N
Retinal Detachment? Y/N
Dry eyes? Y/N
Blurred Vision? Y/N
Do you wear glasses? Y/N
Do you wear contact lenses? Y/N Type ____
If no, have you thought about contact lenses? Y/N
Do you have any questions about Laser Vision Correction Surgery? Y/N
What is the main reason for your visit today? ____
How many hours each day do you use a computer? ______

Emergency Contact

Name ______________________________________ Relation to Patient_________________________
Home Phone Number_________________________ Daytime Phone Number ____________________

I agree that I am financially responsible to the office for any charges not covered or paid by my insurance. I hereby authorize the office to furnish information to insurance carriers concerning these services. I assign to the office all payments for service rendered and all major medical benefits as appropriate.

Patient/Guardian Signature______________________________ Date__________