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Patient Information Form

Last Name First Name If minor, Parent's Name

Address City State Zip

Email Address

Home Phone Work Phone Cell Phone

Date of Birth Age Occupation

How did you hear about us? _____

Date of last eye exam: _____ Reason for today's visit? _____

Do you have any history of eye problems? _____

Have you had any of the following?

Eye Surgery Y / N **Eye Infections Y / N** **Eye Injury Y / N**

Do **YOU** have any history of general health problems, such as:

Diabetes Y / N **High Blood Pressure Y / N** **Other _____**

Is there a family history of:

Cataracts Y / N **Glaucoma Y / N** **Diabetes Y / N**
Blindness Y / N **Macular Degeneration Y / N** **High Blood Pressure Y / N**

Are you taking any medications? (please list) _____

Are you allergic to any medications? (please list) _____

As part of your eye exam, we may use drops to dilate your pupils. This will blur your vision for several hours and affect your ability to drive. May we dilate your eyes today? **Yes / No**

Do you have vision insurance? **Yes / No** Insurance ID#: _____

Insurance Co. Name: _____ Insured's Employer: _____

Name of person insurance is through: _____ Insured's Date of Birth: _____

Insured's relation to you: **Self / Spouse / Parent / Other** Insured's SS#: _____

I authorize the release of any medical or other information necessary to process claims arising from services provided. I assume all financial responsibility for this account and all amounts due regardless of insurance coverage.

I have read and understand my rights under federal HIPPA laws.

Signature **Date**

Relationship (if signing for a minor)