Dr. Mr. Mrs. Ms. Miss______________________________________ Today's Date__________________________

Address:____City:________________State:_____Zip Code:__________

Home phone:_____________________________ Cell phone:____________________________

Email address_____________________________ Occupation:____________________________

Employer:____ Work phone:___________________________

Date of Birth:_______________ Height:_________ Weight:_______ Non-smoker / Smoker

Emergency contact name:_____________________________ Phone number_____________________________

Medical Information

What is your general health?___________________________ Last BP Reading_______________

Do you have problems with any of these symptoms? (Circle yes or no)

Gastrointestinal yes/no Nervous yes/no Endocrine (glands) yes/no

Ears/Nose/Throatyes/no Urinary yes/no Blood/Lymph yes/no

Cardiovascular yes/no Muscles/Bones yes/no Allergic/Immunologic yes/no

Respiratory yes/no Headaches yes/no Integumentary (skin) yes/no

High Blood Press. yes/no Eyes yes/no Mental yes/no

Please explain____

Diabetes Yes/ No Type______________________________ Date of diagnosis_____________________

Allergies to medications or other? Yes/No Which?____

Reaction?____

Other health problems____

Name of family Doctor_______________________________ Date of last visit?________________________

Current medications____

____

____

____

____

Personal Eye Information

Have you had any eye operations? Yes/No

Type?_______________________________ Date?___________________________

Have you had an eye injury? Yes/No

Type?______________________________ Date?___________________________

Do you have glaucoma?Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No

Do you wear glasses? Yes/No Contact lenses?Yes/No
Type_________________________

Additional information____

____

Family History

High Blood Pressure yes/no relation____________ Diabetes yes/no relation____________

Macular degeneration yes/no relation____________ Cataracts yes/no relation_____________

Retinal detachment yes/no relation_______________ Glaucoma yes/no relation_______________

Doctor Use Only

Reviewed by__________Date_______( ) No changes except as noted from previous eye examination on_____________

Reviewed by__________Date_______( ) No changes except as noted from previous eye examination on_____________

Reviewed by__________Date_______( ) No changes except as noted from previous eye examination on______________

Reviewed by__________Date_______( ) No changes except as noted from previous eye examination on______________

Insurance Information

***Please list the subscriber of the policy, if other than the patient.

Primary:_________________________ Policy#___________________________

Address:____

Group#:___________________________

Secondary:_________________________ Policy#___________________________

Address:____

Group#___________________________

Subscriber:_________________________ SSN#:______/____/______DOB:____________

Subscribers Employer:____

Send Bill To: Patient_____ Employer______ Other/Relationship:_______

Method of Payment: Cash_____ Check_____ Credit Card_____

I authorize the release of any medical information necessary to process all claims.

I authorize the release of payment for medical benefit to my physician.

I take full responsibility for all medical expenses incurred.

Patient's signature:_______________________________________ Date:______________________

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: ______________________________ Date: