PATIENT HISTORY FORM

Date: _______________

Patient's First Name: ____________________ M.I.: _____ Last Name: _________________________ Sex: M F

Spouse/Parent's Name:_____________________ Patient's Date of Birth: _____________ Patient's Age: _________

Address__________________________ City: ____________________ State: ____________ Zip: ____________

Home Phone: ____________________ Today's method of payment (Please Circle) Cash Check Credit Card

E-mail address: ____

(If patient is a minor please include parent's work information below)

Place of Employment: ____________________ Occupation: __________________ Work Phone: ______________

Do you have insurance coverage for eye examinations? Yes No (If so, please fill in insurance information below.)

Insurance Company: ___________________ Insured's Name: ___________________ Policy #: ________________

Group # or Name: ____ Insured's Date of Birth: ________________

Insured's Place of Employment: ____________________ Have you met your deductible? _____ Amount of Co-Payment?______

__All charges incurred are due at the time of service.__ Currently we do not accept vision insurance on assignment. However, we will provide you with a medical statement which many insurances will use to reimburse you directly.

How were you referred to our clinic? Yellow Pages ____ Wal-Mart ____ Insurance Listing ____ Relative ____

Other ______________________________

VISUAL AND MEDICAL HISTORY

Reason for today's visit?: ____

Date of last eye exam? ____________________ By Whom? ____

Do you presently wear? (Circle) Glasses Contacts Both

If not currently wearing contacts, are you interested in trying them today? Yes / no

If you wear contact lenses do you know what kind, type or brand you wear? _________________________________

How old are your contacts? _____________________

Please check any condition that applies to yourself or any members of your immediate family:

	Self	Family		Self	Family
Diabetes	_____	_____	Retinal Detachment	_____	_____
High Blood Pressure	_____	_____	Eye Surgery	_____	_____
Heart Problems	_____	_____	Lazy Eye	_____	_____
Respiratory Problems	_____	_____	Cataracts	_____	_____
			Glaucoma	_____	_____

Medications you are currently taking? ____

What allergies do you have if any? ____