

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City: _____ Zip: _____
Title: Mr. Mrs. Miss Ms. Other: _____ Sex: M F Date of Birth _____
Social Security #: xxx-xx-_____ Please circle the best # you can be reached at:
Home: _____ Work: _____ Cellular: _____ Other: _____
Employer: _____ Job Title: _____
Other family members who have been to our office? _____

School Attending: _____ Grade _____

INSURANCE INFORMATION

-Vision Service Plan- -Medical Eye Services-
-Davis Vision- -Superior Vision- Other: _____
Insured Members Name: _____ DOB ___/___/___ SSN: xxx-xx-_____
Do you have secondary insurance? If so, what ins. company? _____
Insured Members Name: _____ DOB ___/___/___ SSN: xxx-xx-_____
What influenced you to select our office? _____
Were you referred by someone else? Y N If so, by whom? _____

MEDICAL INFORMATION

Do any of your blood relatives have Diabetes? Y N If so, who? _____
Do you have any of the following? (If so, please list medications):
High Blood Pressure: _____ Allergies: _____
Diabetes? ___ type 1 or 2 (circle) When was insulin last taken? _____
Hypoglycemia: _____ Arthritis: _____
Heart Conditions: _____ Thyroid: _____
Headaches: _____ Sinus: _____
Other: _____
Have you ever had an allergic reaction to any medications? Y N
If so, please list medications: _____

MEDICAL INFORMATION CONT'D...

Have you ever had:

Ocular Surgery? Y N Explain: _____

Ocular Injury/Disease? Y N Explain: _____

Vision Therapy? Y N For: _____

Do you wear glasses? Y N If so, how long? _____

Do you wear contact lenses? If so, how long? _____ soft or hard lenses? _____

When was your last eye exam? _____ Previous Eye Doctor: _____

Are you happy with your current glasses? Y N

What can we do to improve your glasses? _____

Do you have any visual needs not being met? _____

Do any blood relatives have: -Macular Degeneration- -Color Blindness- -Glaucoma-
-Retinal Detachment- -Retinitis Pigmentosa- -Crossed Eyes-

Hobbies and sports you enjoy: _____

Comments: _____

SIGNATURE ON FILE

- I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.
- I authorize use of this form on all of my insurance submissions.
- I authorize release of information to all of my insurance companies.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Print Name: _____ Signature: _____

Social Security or ID#: xxx-xx-_____ Date: _____