## Patient Information

Patient Last Name: ____________ First Name: ____________ ☐ M ☐ F Date: ____________

Social Security No: ____________ Date of Birth: ____________

Mailing Address: ______________________________
(Street) (City) (State) (Zip)

Billing Address: same as above ☐ ______________________________
(Street) (City) (State) (Zip)

Occupation: ____________ Employer: ____________

Children at Home: ____________ ____________ Hobbies: ____________
(Name) (Age) (Name) (Age)
____________ ____________ ____________
(Name) (Age) (Name) (Age)

Who can we thank for referring you to our office? ____________

## Contact Information

*Any information provided here will be used solely to notify you of appointments, or when product is ready for pickup. Your information will never be used for solicitation or shared outside of our office.*

Home Phone Number: ____________

Cell Phone Number: ____________ *Carrier: ____________

Business Phone Number: ____________

Email Address: ____________

I prefer to be contacted first via:

☐ Home Phone ☐ Cell Phone

☐ Bus. Phone ☐ Email

☐ Text to cell phone number*

## Vision Insurance Holder – Member Information

Member's Full Name: ____________

Street Address: ____________ Vision Insurance Company: ____________

____________ Member's Insurance ID (SSN): ____________

City ____________ Member's Date of Birth: ____________

State: ____________ Zip: ____________ Member's Relationship to Patient: ____________

## Major Medical Insurance Holder – Member Information

Member's Full Name: ____________

Street Address: ____________ Medical Insurance Company: ____________

____________ Member's Insurance ID (SSN): ____________

City ____________ Member's Date of Birth: ____________

State: ____________ Zip: ____________ Member's Relationship to Patient: ____________

## Any Secondary Insurance (Vision or Medical)

Member's Full Name: ______________________

Street Address: ______________________ Insurance Company: ______________________

______________________ Member's Insurance ID (SSN): ______________________

City ______________________ Member's Date of Birth: ______________________

State: __________ Zip: __________ Member's Relationship to Patient: ______________________

## Eye Health and Refractive History

What is the main reason for today's visit? ______________________

Date of your last eye examination: ______________________ Name of Doctor: ______________________

Do you wear glasses? ☐ Yes ☐ No Glasses are worn: ☐ Full Time ☐ Part Time

Do you currently wear contact lenses? ☐ Yes ☐ No If yes,Type & Brand: ______________________

Current prescribed or OTC eye drops: ______________________

List any previously diagnosed eye conditions: ______________________

List any known family eye diseases: ______________________

## General Health History

Name of primary care physician: ______________________ Phone: ______________________

Current prescribed or OTC medications: ______________________

______________________

List any diagnosed systemic conditions: ______________________
(high blood pressure; diabetes; thyroid dysfunction; asthma; etc.)

______________________

List any known medication allergies: ______________________

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered. Accounts 90 days old are subject to collection fees, unless other arrangements are made in advance.

Liability Statement:

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company. Final determination can only be made when the claim is processed. If my insurance denies payment for any reason, I understand that I am responsible for the unpaid balance. My signature below is verification that I understand this agreement.

Signature: ______________________ Date: ______________________