

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Medical Insurance Co: \_\_\_\_\_ *If you have Vision Insurance:*

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Insured Person: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured Person: \_\_\_\_\_

Relationship: \_\_\_\_\_

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign  
*(name of insurance company)*  
directly to Dr. \_\_\_\_\_ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

**Medical & Visual History**

Please check all that apply:

	Self	Family	Relationship		Self	Family	Relationship
Cataracts					Diabetes		
Glaucoma					High blood pressure		
Macular degeneration					High cholesterol		
					Do you smoke?		

Current medications- Prescribed: \_\_\_\_\_

Over-the-Counter: \_\_\_\_\_

Allergies: \_\_\_\_\_

Frequent headaches? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Date of last vision examination: \_\_\_\_\_ Examining doctor: \_\_\_\_\_

Do you currently wear glasses? \_\_\_\_\_ contact lenses? \_\_\_\_\_

Full time       S       B      Disposable  
 Di      oft      ifocal  
 stance only       T      Daily      Daily wearing time: \_\_\_\_\_  
 Nea      oric      wear      Replacement schedule: \_\_\_\_\_  
 r only      igid      wear      Extended Disinfecting system: \_\_\_\_\_

Special visual tasks: \_\_\_\_\_

Reason for today's appointment: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_