Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

What is your reason for visit? _____ Last exam date _____

CONDITIONS Check(✓) conditions you have or have had in the past.

☐ Blurred Vision	☐ Double Vision	☐ Floaters	☐ Loss of Vision	☐ Sensitivity to Light
☐ Cataracts	☐ Eye Infection	☐ Glaucoma	☐ Retinal Disease	☐ Wear Contact Lenses
☐ Crossed Eyes	☐ Eye Injury	☐ Headaches	☐ Seeing Flashes	Type of Lenses _____
☐ Diabetes	☐ Eye Surgery	☐ Hypertension	☐ Seeing Halos	Hours per Day _____

Check (✓) if your blood relatives had any of the following:

	Disease	Relationship to you
	Blindness	
	Cataracts	
	Diabetes	
	Glaucoma	

ALLERGIES you have to medications or substances

MEDICATIONS List medications you are currently taking

(Vers.O2SSS04)

INSURANCE INFORMATION

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber I.D. # _____

AUTHORIZATIONS

I certify that I have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____ for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative Date

Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary