Patient Record

(Please Print)

□Mr. □Mrs. □Ms. _____ E-Mail-_____
Address: _____
City: _____ State:_____Zip: _____
Home Phone: _____Alternate Phone: _____
Occupation: _____
Date of Birth: _____Age:_____
Have you previously been seen at this location: □Yes □No
Last eye exam date: _____From Dr._____
Family Physician: _____Referred By: _____
With whom may we discuss your health information? (name, relationship, phone number):
_____

Are you using insurance: □Yes □No Name of insurance: _____

Do you wear:
Glasses: □Yes □No Age of Current Pair:_____
Contact Lenses: □Yes □No Age of Current Pair:_____

Please list all medications: _____
□Aspirin Regularly □Vitamins □Antihistamines □Birth Control Pills

Please list all allergies:_____

Do **YOU** have any history of the following:

□Blurred Vision	□Eye Surgery	□Dry Eyes	□Floaters/Spots
□Burning/Itching	□Eye Injury	□Eye Allergies	□Excessive Tearing
□Double Vision	□Flashes/Sparks	□Currently Pregnant/Nursing	

Do **YOU** or any **FAMILY MEMBERS** have any history of the following:

□Blindness Who:_____	□Retinal Problems Who:_____	□Heart Disease Who:_____
□Cataracts Who:_____	□Retinal Detachment Who:_____	□High Blood Pressure Who:_____
□Glaucoma Who:_____	□Diabetes Who:_____	□Thyroid Problems Who:_____
□Macular Degeneration Who:_____	□Headaches Who:_____	□Cancer Who:_____

Financial Policy: Payment is expected on day of visit. We accept cash, debit cards, or credit cards. We do not accept checks. Professional fees are non-refundable. Please be aware that some services may not be covered under your insurance plan, and are therefore your responsibility. Your signature indicates that you agree to be financially responsible for any balance not paid by your insurance plan.

Signature:_____ Date:_____