

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

DATIENT INCODUAL	101		INCURANCE			
PATIENT INFORMAT	1 U N		INSURANCE			
Date		Who is responsible for this account?				
SS/HIC/Patient ID #	<u> </u>	Relationship to Patient				
Patient Name		Insurance Co.				
Last Name		Group #	ALI DETI	er met team A		
First Name	Middle Initial	Is patient covered by additional insurance? Yes No				
Address	Subscriber's Name					
City	<u></u>	Birthdate				
State Zip		Relationship to Patient				
E-mail	n y O manin	Insurance Co.				
Sex M F Age Birthdate		Group #				
☐ Married ☐ Widowed ☐ Single		ASSIGNMENT AND RELEASE				
☐ Separated ☐ Divorced ☐ Partnered		I certify that I, and/or my dependent(s), have insurance coverage with				
		and assign directly to Name of Insurance Company(ies)				
Occupation		Dr all insurance benefits, if				
Patient Employer/School		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				
Employer/School Address		the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose				
4 - 1 - 1 - 1		such information to the ab	ove-named Insurance Company(i	es) and their agents		
Employer/School Phone () for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end wh						
Spouse's Name	<u></u>	my current treatment plan	is completed or one year from the	e date signed below.		
Birthdate SS#	Signature of Patient, Parent, Guardian or Personal Representative					
Spouse's Employer						
Whom may we thank for referring you? Please print name of Patient, Parent, Guardian or Personal Representative						
		Date	Relationshi	p to Patient		
	PHONE N	IIMDEDC				
Harras (
Home () Cell (_)	Spouse's Work	Phone ()	Ext		
Best time and place to reach you	someone who does not live	in your household)				
Name		e to the second of the second				
Home () Cell (_						
nome ()Cell (_		vvork Phone ()	EXT		
	EYE HEALTH	HISTORY				
Physician's Name			ve had any of the following:			
Date of last visit	Bloodshot Eyes	Yes No	Floaters or Spots	☐ Yes ☐ No		
Date of last visit	Blurred Vision – Distance Blurred Vision – Near	Yes No	Glaucoma Headaches	☐ Yes ☐ No ☐ Yes ☐ No		
	Burning Eyes	Yes No	Itching Eyes	Yes No		
Name of doctor Do you wear glasses? ☐ Yes ☐ No	Cataracts Color Vision, Poor	☐ Yes ☐ No	Light Sensitive Loss of Vision	☐ Yes ☐ No ☐ Yes ☐ No		
☐ All the time ☐ Occasionally	Crossed Eyes	Yes No	Migraine Headaches	Yes No		
☐ Reading ☐ Driving ☐ TV	Discharge from Eyes Dizzy Spells	☐ Yes ☐ No	Night Vision, Poor Red Eyes	☐ Yes ☐ No ☐ Yes ☐ No		
Do you wear contacts? ☐ Yes ☐ No	Double Vision	Yes No	Seeing Halos	Yes No		
Type Hours/Day	Dry Eyes	Yes No	Seeing Flashes	Yes No		

contacts _

Describe any problems you have with your

Eye Injury

Eye Strain

Eye Infection

Fainting Spells, Blackouts

Yes No

Yes No

Yes No

Yes No

Twitching Eyelid

Vision Poor

Watering Eyes

Temporary Loss of Vision

Yes No

Yes No

Yes No

Yes No

HEALTH HISTORY							
Physician's Name	0.0 Pv@1		Date of last	visit			
Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.							
AIDOUNA	Yourself	Family Members	Hamatika (Tona	Yourself Family Members			
AIDS/HIV	Yes No	Yes No	Hepatitis (Type)	☐ Yes ☐ No ☐ Yes ☐ No			
Arthritis	☐ Yes ☐ No	Yes No	High Blood Pressure	Yes No Yes No			
Artificial Heart Valve	Yes No	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No ☐ Yes ☐ No			
Artificial Joints	Yes No	☐ Yes ☐ No	Lazy Eye	Yes No Yes No			
Asthma	Yes No	☐ Yes ☐ No	Lupus	☐ Yes ☐ No ☐ Yes ☐ No			
Bleeding	Yes No	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No ☐ Yes ☐ No			
Blindness	Yes No	☐ Yes ☐ No	Pacemaker	Yes No Yes No			
Cancer	Yes No	Yes No	Poor Color Vision	Yes No Yes No			
Cataracts	☐ Yes ☐ No	Yes No	Retinal Disease	☐ Yes ☐ No ☐ Yes ☐ No			
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No ☐ Yes ☐ No			
Diabetes	Yes No	☐ Yes ☐ No	Shingles	☐ Yes ☐ No ☐ Yes ☐ No			
Drug Sensitivity	Yes No	☐ Yes ☐ No	Skin Conditions	☐ Yes ☐ No ☐ Yes ☐ No			
Emphysema	☐ Yes ☐ No	Yes No	Stroke	☐ Yes ☐ No ☐ Yes ☐ No			
Epilepsy	☐ Yes ☐ No	Yes No	Thyroid Conditions	☐ Yes ☐ No ☐ Yes ☐ No			
Eye Surgery	Yes No	Yes No	Tuberculosis	☐ Yes ☐ No ☐ Yes ☐ No			
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Turned Eye	☐ Yes ☐ No ☐ Yes ☐ No			
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No	Are you pregnant?	Number of children			
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No	Tobacco use	Alcohol use			
MFDI	CATIONS		λ11.	ERGIES			
List any medications you are currently taking, including eye drops: List your allergies to medications or other substances:							
Dharasay Mara							
Pharmacy Name Phone ()							
rnone ()							
	MEDI	CARE/MEDIG	AP 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 for any services turnished to me by that provider.							
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			ative	Date			
Please print name of Beneficiary, Guardian or Personal Representative			sentative	Relationship to Beneficiary			

