WELCOME TO OUR OFFICE

Name_____ Sex M / F Birthdate_____ Age_____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Occupation_____Hobbies_____

Prev. eye Dr._____Approx. date last exam_____

How did you hear about our office? (Circle) Walk in Yellow pages Referral_____

Name of Insurance_____Employer_____Group_____

Insured's Name _____**Insured's** ID# / Date of Birth_____/_____

Do wear glasses? ____Y ____N To be used ____Always ____Reading only ____Distance only

Do you wear contact lenses? ____Y ____N What type? ____Soft daily wear ____Rigid gas perm.
____Disposable ____Overnight wear

Are you interested in wearing contact lenses? ____Y ____N

Purpose of this visit. State any problems you are having_____

_____

Have you ever had an eye disease, infection, injury, surgery? Please list_____

Health History: *Please circle any health conditions you or any of your immediate family members have:*

Diabetes:	self / family	High Blood Pressure:	self / family
Heart Condition:	self / family	Asthma:	self / family
Glaucoma:	self / family	Eye Disease:	self / family

Please indicate any health condition(s) that **YOU PERSONALLY** have / had:

Y or N	Double Vision	Y or N	Dry eyes	Y or N	Flashes / Floaters
Y or N	Thyroid trouble	Y or N	Arthritis	Y or N	Do you smoke?
Y or N	Frequent Headaches	Y or N	Seizures	Y or N	Migraines
Y or N	Allergies (Seasonal)	Y or N	Sinusitis	Y or N	Women: Are you pregnant?
Y or N	Anemia	Y or N	Hepatitis	Y or N	Other medical conditions

List medications currently taking_____

List drug allergies_____

DILATING THE EYE

Many diseases such as diabetes, hypertension, glaucoma and tumors of the eye as well as tears and holes of the retina can be detected with dilation. A dilation requires placing drops in the eyes to enlarge the pupil which allows a thorough examination of the inside of the eye for these and other problems. The side effects are blurred near vision and light sensitivity for about 3 - 4 hours. The Dr. may recommend that a dilation be performed. There is no additional charge for this procedure.

Professional fees are due upon completion of services. although we do bill some insurances, please be advised that payment is still your responsibility. For your convenience we accept Visa and Mastercard. NOTE: ALL RETURNED CHECKS ARE SUBJECT TO A $15.00 CHARGE.

ASSIGNMENT AND RELEASE:

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. I ALSO AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN, AND I UNDERSTAND I AM RESPONSIBLE FOR NON-COVERED SERVICES.

Signed (Parent or guardian if minor)_____Date_____