PATIENT WELCOME FORM

Date_____

At today's visit I would like:

Annual Eye exam_____ Laser vision consultation____

Contact lens exam_____ Contact lens consultation_____

PATIENT INFORMATION

_____

Last name First MI male___

_____ female___

DOB Social Security last four digits email

_____

Address City Zip

_____

Home phone work phone cell phone

Occupation_____ Employer_____

Whom may we thank for referring you to our office?_____

PATIENT GENERAL HEALTH(mark all that apply)

Allergies/hay fever	Gastrointestinal	Thyroid/Endocrine
Asthma/Respiratory	Nervous	Skin disorders
Blood disorders	Cardiovascular	Mental/psychiatric
Cancer	Blood Pressure	Headaches

Diabetes_____type 1 or type 2 Date of diagnosis_____

Current diabetes treatment ? Medication Insulin None

Are you currently pregnant Yes/ No or nursing? Yes/ No

PATIENT EYE HEALTH(mark all that apply)-Main reason for visit today?_____

Amblyopia(lazy eye)	Eye redness	Spots/floaters
Blurred vision	Glaucoma	Eye turn/crossed
Burning eyes	Cataracts	Eye injuries/surgeries
Dry/watery/itchy	Retinal detachment	Macular degeneration

FAMILY HISTORY(blood relatives)

Glaucoma	Color blindness	Amblyopia(lazy eye)
Macular degeneration	Diabetes	High blood pressure

PLEASE COMPLETE OTHER SIDE

Name of family physician_____Date of last visit_____
MEDICATIONS/PILLS TAKEN BY PATIENT(and condition taken for)
1._____5._____
2._____6._____
3._____7._____
4._____8._____
Please list medications that cause patient allergic reaction:_____

PATIENT EYE HISTORY
Have you ever worn eyeglasses? Yes/ No Have you ever worn contact lenses Yes/No
How old are you present eyeglasses?_____Last eye exam?_____
Do you presently wear eyeglasses? Yes/No If yes, for Distance Reading Computer
Do you presently wear contact lenses? Yes/No Current brand?
I am interested in wearing contact lenses Yes/No

INSURANCE INFORMATION
Vision Insurance(please check all that apply) VSP WHA MESC EYEMED
BLUECROSS MEDICARE TRICARE MEDICAID OTHER
Name of insured_____Insured's phone number_____
Patient relationship to insured : Self Spouse Child Other_____
Insured's ID___ Group # Insured's DOB_____
Is there any secondary vision insurance? If so, type_____

PATIENT MEDICAL INSURANCE
Name of medical insurance_____Group #_____
Insured's name_____ Insured's DOB_____

PAYMENT POLICY
Payment for professional services is required on the day services are provided. Your insurance authorization is not a guarantee of payment and is billed as a courtesy.
If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. I agree that I am personally responsible for payments as per the office policy above.

Signature _____ Date_____
THANK YOU