New Patient Information

GENERAL INFORMATION

Last Name: _____
First Name: _____
Middle Initial: _____
Preferred Name: _____
Address: _____
Suite/Apartment: _____
City, State, Zip: _____
Birthdate: _____
Marital Status: _____
Main Contact: _____
Phone: _____
Relationship to Patient: _____

Gender: _____
S.S.N: _____
Race: _____
Language Preference: _____
Employer: _____
Occupation: _____
Work Phone: _____
Home Phone: _____
Cell Phone: _____
Email: _____
Preferred Communication: Call Text Email
Who may we thank for referring you to our office?

INSURANCE INFORMATION

	Medical Insurance	Vision Insurance
Insurance Company:	_____	_____
Subscriber Name:	_____	_____
Subscriber Date of Birth:	_____	_____
Subscriber Number:	_____	_____
Group Number:	_____	_____

Reason for Visit:_____
_____
_____

Medications: _____
_____
_____
_____

Vitamins & Supplements: _____
_____

Allergies: _____
_____
_____

PATIENT & FAMILY HISTORY

Do you or any of your family members have a history of the following:

	Self	Family
Glaucoma	____	____
Cataracts	____	____
Macular Degeneration	____	____
High Blood Pressure	____	____
High Cholesterol	____	____
Diabetes	____	____
Eye Surgery	____	____
Cancer	____	____
Migraines	____	____
Asthma	____	____

GENERAL INFORMATION

Glasses Wearer: Yes No

If yes, do you currently have difficulty with: (Check all that apply)

Night Vision | Computer Use | Work | Sewing

Watching Television | Driving | Reading | Other_____

Do your eyes: Burn Water Itch

Ache Tire

Are they sensitive to light: Yes No

Which type:

Sun | Fluorescent | Glare | Snow | Other_____

Contact Lens Wearer: Yes No

If yes, are they: Soft Rigid

If no, are you interested: Yes No

Are you interested in learning about Laser Vision correction: Yes No

Do you use a computer at: Work Home

How many hours:

When computing, do your eyes become: Red Dry Sore Achy Other _____

LIFESTYLE INFORMATION

Hobbies and recreational activities:

Basketball | Video Games | Hiking

Camping | Hunting | Cycling

Playing Musical Instrument | Flying | Motorcycle Riding

Swimming | Card Games | Baseball/Softball

Sewing | Golfing | Other_____

We are happy to assist you in the filing of your insurance claim. If your insurance will not pay for the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is requested and the balance is due upon delivery. We accept cash, personal checks, Visa, Discover and Mastercard. A 1.5% late fee will be charged each month to any unpaid balance.

Payment Method: Personal Check | Cash | Credit Card | Insurance

Signature_____ Date_____