Name: ____ **Date of Birth:** _____________________________

Email Address: ____

Address: ___________________________________ **City:** _________________ **ST:**____ **Zip:** __________

Cell Phone: _________________ **Home Phone:** __________________ **Work Phone:** ___________________

Employer: ____________________________________ **Occupation:** __________________________________

Medical Insurance: _____________________ **Medical Insurance Member ID:** ___________________________

Vision Insurance: ______________________ **Vision Insurance Member ID:**_____________________________

Social Security Number: ______________________ **Primary Insured last four of SSN:** ___________________

Primary Insured Name, DOB, Address, and Relationship to Insured (if different than above):

____

I authorize the release of any medical or other information to process my insurance claims. I also authorize my payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for services performed by that doctor. I understand that I am responsible for any charges that are not covered by my insurance. Signing this document also signifies that I understand, have been offered, or read a copy of our HIPAA Privacy Policy.

X___________________________________

Medications:

____

____

Height: _______________________________ **Weight:** ____

Allergies to Medications: ____

Are you Pregnant or Nursing?: _____________ **Do you use tobacco:** ____________________________

Have you worn contact lenses?: _____________ **Interested in contacts:** _________________________

Have you had any eye surgeries?: ____

When was your last Eye Exam?: ____

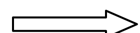
Are you sensitive to sunlight?: ____

How many hours per day do you spend outdoors?: ____

What are your favorite indoor/outdoor activities?: ____

What do you currently use glasses for?: ____

Please continue to back



Do you know what Harmful Blue Light is?: ______

Are you concerned about Harmful Blue Light?: ______

How many hours per day do you spend on a screen?: ______

How did you hear about our office?: ______

If referred, by whom?: ______

Check all that apply:

	Self	Family
Allergic/Immunologic		
Drug Allergy	____	____
Environmental Allergy	____	____
Rheumatoid Arthritis	____	____
Lupus	____	____
Eyes		
Glaucoma	____	____
Cataracts	____	____
Macular Degeneration	____	____
Inflamatory Disorders	____	____
Blurred Vision	____	____
Double Vision	____	____
Musculoskeletal		
Fibromyalgia	____	____
Muscular Dystrophy	____	____
Osteoarthritis	____	____
Ankylosing Spondylitis	____	____
Cardiovascular		
Heart Disease	____	____
Hypertension	____	____
Stroke	____	____
Vascular Disease	____	____
High Cholesterol	____	____
Gastrointestinal		
Crohn's	____	____
Colitis	____	____
Ulcer	____	____
Digestive	____	____
Neurological		
Multiple Sclerosis	____	____
Headaches	____	____
Epilepsy	____	____
Alzheimers	____	____
Parkinsons	____	____
Cerebrovascular	____	____

	Self	Family
Constitutional		
Developmental disability	____	____
Weight Loss	____	____
Fever	____	____
Fatigue	____	____
Trauma	____	____
Genitourinary		
STD	____	____
Viral Herpetic	____	____
Chlamydia	____	____
Ear, Nose, Mouth & Throat (Chronic or Current)		
Upper Resp. Tract Infection	____	____
Ear Ache	____	____
Runny Nose	____	____
Sore Throat	____	____
Ringing/Tinnitis	____	____
Hematologic/Lymphatic		
Anemia	____	____
Large volume blood loss	____	____
Leukemia	____	____
Respiratory		
Smoker	____	____
Asthma	____	____
Bronchitis	____	____
Emphysema	____	____
Endocrine		
Diabetes Type 1	____	____
Diabetes Type 2	____	____
Thyroid Dysfunction	____	____
Hormonal Dysfunction	____	____
Integumentary/Skin		
Eczema	____	____
Rosacea	____	____
Psoriasis	____	____

Signature: ______ Date: ______