



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?: \_\_\_\_\_

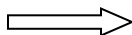
How many hours per day do you spend outdoors?: \_\_\_\_\_

What are your favorite indoor/outdoor activities?: \_\_\_\_\_

What do you currently use glasses for?: \_\_\_\_\_

How many hours do you spend on a screen?: \_\_\_\_\_

Please continue to back



How did you hear about our office?: \_\_\_\_\_

If referred, by whom? \_\_\_\_\_

***Check all that apply:***

	Self	Family		Self	Family
<b>Constitutional</b>			<b>Genitourinary</b>		
Developmental Disability	_____	_____	Kidney Disease	_____	_____
Cancer	_____	_____	Prostate Disease/Cancer	_____	_____
Fatigue Syndrome	_____	_____	STD - Herpetic/Chlamydia	_____	_____
<b>Ear, Nose, Mouth &amp; Throat (Chronic or Current)</b>			Benign Prostate Hypertrophy	_____	_____
Hearing Loss	_____	_____	<b>Musculoskeletal</b>		
Sinusitis	_____	_____	Arthritis	_____	_____
Dry mouth	_____	_____	Osteoarthritis	_____	_____
Laryngitis	_____	_____	Fibromyalgia	_____	_____
<b>Neurological</b>			Muscular Dystrophy	_____	_____
Multiple Sclerosis	_____	_____	Ankylosing Spondylitis	_____	_____
Epilepsy	_____	_____	Osteoporosis	_____	_____
Cerebral Palsy	_____	_____	Gout	_____	_____
Tumor	_____	_____	<b>Integumentary/Skin</b>		
Stroke/CVA	_____	_____	Eczema	_____	_____
Migraine	_____	_____	Rosacea	_____	_____
Autism Spectrum Disorder	_____	_____	Psoriasis	_____	_____
<b>Psychological</b>			Herpes Simplex/Cold Sores	_____	_____
Depression	_____	_____	Herpes Zoster/Shingles	_____	_____
Attention Deficit	_____	_____	<b>Endocrine</b>		
Anxiety Disorder	_____	_____	Diabetes Melitus Type 1	_____	_____
Bipolar Disorder	_____	_____	Diabetes Melitus Type 2	_____	_____
<b>Cardiovascular</b>			Thyroid Dysfunction	_____	_____
Hypertension	_____	_____	Hormonal Dysfunction	_____	_____
Stroke/CVA	_____	_____	<b>Hematologic/Lymphatic</b>		
Heart Disease	_____	_____	Anemia	_____	_____
Vascular Disease	_____	_____	Large Volume Blood Loss	_____	_____
Congenitive Heart Failure	_____	_____	Ulcer	_____	_____
<b>Respiratory</b>			High Cholesterol	_____	_____
Cigarette Smoker	_____	_____	<b>Allergic/Immunologic</b>		
Asthma	_____	_____	Drug Allergy	_____	_____
Bronchitis	_____	_____	Environmental Allergy	_____	_____
Emphysema	_____	_____	Rheumatoid Arthritis	_____	_____
Chronic Obstruction	_____	_____	Lupus	_____	_____
Sleep Apnea	_____	_____	<b>Eyes</b>		
<b>Gastrointestinal</b>			Glaucoma	_____	_____
Crohn's	_____	_____	Cataracts	_____	_____
Colitis	_____	_____	Macular Degeneration	_____	_____
Ulcer	_____	_____	Inflammatory Disorders	_____	_____
Acid Reflux	_____	_____	Blurred Vision	_____	_____
Celiac Disease	_____	_____	Double Vision	_____	_____

Signature: \_\_\_\_\_

Date: \_\_\_\_\_