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
Constitutional		
Developmental Disability		
Cancer		
Fatigue Syndrome		
Ear, Nose, Mouth & Throat (Chronic or Current)		
Hearing Loss		
Sinusitis		
Dry mouth		
Laryngitis		
Neurological		
Multiple Sclerosis		
Epilepsy		
Cerebral Palsy		
Tumor		
Stroke/CVA		
Migraine		
Autism Spectrum Disorder		
Psychological		
Depression		
Attention Deficit		
Anxiety Disorder		
Bipolar Disorder		
Cardiovascular		
Hypertension		
Stroke/CVA		
Heart Disease		
Vascular Disease		
Congenitive Heart Failure		
Respiratory		
Cigarette Smoker		
Asthma		
Bronchitis		
Emphysema		
Chronic Obstruction		
Sleep Apnea		
Gastrointestinal		
Crohn's		
Colitis		
Ulcer		
Acid Reflux		
Celiac Disease		

	Self	Family
Genitourinary		
Kidney Disease		
Prostate Disease/Cancer		
STD - Herpetic/Chlamydia		
Benign Prostate Hypertrophy		
Musculoskeletal		
Arthritis		
Osteoarthritis		
Fibromyalgia		
Muscular Dystrophy		
Ankylosing Spondylitis		
Osteoporosis		
Gout		
Integumentary/Skin		
Eczema		
Rosacea		
Psoriasis		
Herpes Simplex/Cold Sores		
Herpes Zoster/Shingles		
Endocrine		
Diabetes Melitus Type 1		
Diabetes Melitus Type 2		
Thyroid Dysfunction		
Hormonal Dysfunction		
Hematologic/Lymphatic		
Anemia		
Large Volume Blood Loss		
Ulcer		
High Cholesterol		
Allergic/Immunologic		
Drug Allergy		
Environmental Allergy		
Rheumatoid Arthritis		
Lupus		
Eyes		
Glaucoma		
Cataracts		
Macular Degeneration		
Inflamatory Disorders		
Blurred Vision		
Double Vision		

Signature: _____ Date: _____