WELCOME TO OUR OFFICE

First Name ____________ Middle Initl ______ Last Name ____________ Suffix ______

Gender: ☐Female ☐Male Date of Birth: _____/_____/_______ Age _______ Occupation ____________

Street Address ____________ Apt. # ______ City ____________ State ______ Zip Code ______

Phone ☐cell ☐home ☐work ____________ E-mail ____________ Social Security Number ____________

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

Smoking Status
- ☐ Daily
- ☐ Sometimes
- ☐ Former
- ☐ Never

Marital Status
- ☐ Single
- ☐ Married
- ☐ Other

Height ____________

Weight ____________

Blood Pressure/Heart Rate: ____________

Name Primary Insurance Holder ____________ Relationship to Patient ____________ Date of Birth ____________

Vision	Medical

REASON FOR TODAY'S VISIT

☐Routine Eye Exam ☐Exam to Include Contact Lenses ☐Emergency for Eye Infection ☐Other

Explain "Other" ____________ Last Exam Date ____________

MEDICAL HISTORY

	Self	Family
High Blood Pressure	☐	☐
Heart Condition	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Asthma	☐	☐
Glaucoma	☐	☐

Allergies ____________

Reaction ____________

List Medications:	Dosage	Frequency	Taking For?
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____

Inner Eye Health:

☐Wellness Screening $25 ☐Photography $25

My signature below indicates I am aware of my **HIPAA** rights. It also indicates that I have read and understand the office protocol for **Vision vs. Medical** insurance. I Authorize **release of information** to determine and allow payment of insurance benefits. I understand that all fees for professional services are **non-refundable** and payable at the time of service.

X ____________

Signature (legal Guardian if under 18)

Today's Date ____________

For Doctor's Use Only

Procedure Codes ____________

Diagnosis Codes ____________

Fees:

Exam ________ Dilation ________ CL Fit ________

Other ________ TOTAL ____________

HIPAA___ ID___ Ins in MVE ___Scanned___ Email___ CC Recpt___ Auth___ Ins filed___ Chart___ CCD___ Email Sum___ Order CL___