

Today's Date _____
Patient Name _____ Birthdate _____ Age _____ Marital Status _____
Patient Address _____ City _____ State _____ Zip _____
Patient Home Telephone Number _____ Social Security Number _____
Male _____ Female _____ Name of Nearest Relative _____
(Other than Spouse)
If child, Guardian name _____ Relatives Home Telephone Number _____
Patient Occupation _____
Name of Employer of the patient _____ Employer Telephone Number _____
Employer Address _____
Do you have medical insurance? Yes _____ No _____
If no, how do you intend to pay for today's visit? Cash _____ Check _____
Name of Primary Insurance Company _____
Insurance company address _____
Name of insured _____ Insured Birthdate _____
Insurance Identification Number _____ Group Number _____
Name of Spouse _____ Birthdate of Spouse _____ Social Security Number _____
Name of Employer of Spouse _____ Employer Telephone Number _____
Spouse Employer Address _____
Please list name; address and policy number of any secondary or Medicare supplemental insurance:

Insured Name _____ Policy Number _____

MEDICAL HISTORY

Do you have any of the following?
Diabetes: Yes _____ No _____ If yes, for how long? _____ List medications _____
High Blood Pressure: Yes _____ No _____ If yes, for how long? _____ List medications _____
Please list any other medical problems _____ List medications _____
Are you ALLERGIC to any medications? Yes _____ No _____ Please specify _____
Family Physician's Name and Address _____
Date of last eye exam _____ By whom _____ Address _____
Previous eye surgery? Yes _____ No _____ Specify _____ By whom _____ Date _____
Reason for seeing the Doctor today? _____

Referred by _____