Blvd Eyes

Patient Information Sheet

Primary Care Physician_____ Phone: ( )_____
Are you currently wearing Glasses? Yes / No Contact Lenses? Yes / No

Name: (Mr. Mrs. Ms) _____Date of Birth ____/____/____
___Married ___Widowed ___Single ___ Minor ___ Separated ___ Divorced ___Partnered for ___ years

Address: _____Sex: (Male)___ (Female) ___

City: _____ State: _____ Zip: _____ S.S.# ____/____/____ Age:____

Home Phone (___)_____ Cell Phone (___)_____ Work (___)_____

Employer: _____Occupation:_____
___Full Time ___Part Time ___Self employed ___ Retired ___ Not Employed

Responsible Party for Insurance: _____D.O.B _____ Phone: _____

Responsible Party S.S.# _____/_____/_____ Relationship to patient: _____

Spouse Name: _____ D.O.B. ____/____/____

Spouse SS#: ____/____/____ Spouse employer _____Work # ( )_____

Whom may we thank for referring you?_____

**********INSURANCE INFORMATION**********

Medical Insurance:_____ ID #_____

Group # _____ Vision Insurance:_____ ID #_____

I, the undersigned certify that I (or my dependent) have insurance coverage and assign insurance benefits, if any, directly to provider, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. I agree to cover all charges for myself or my dependent that insurance does not pay. In the event action needs to be taken to collect any non-payment balance, regarding this account, I understand my account will be subject to a collection fee as well as subject to transferal to collection service.

Signature: _____ Date: _____

Our office files insurance as a service to our patients,
but we can not guarantee payment of benefits.

Office Policies

Exam: Exam fees are due the date of service excluding insurances services. All insurance copays are due at time of service.

Contact Lenses: All contact lenses must be paid in full on date of dispensing.

Glasses: All glasses (excluding insurance) require a 50% deposit before processing order, balance will be due at dispensing of glasses.

OVER

Confidential Medical History

Eye Health:
Have you ever had any eye problems
In the following areas:

Wearing Contact Lenses	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Retinal Detachment	Yes	No
Lazy Eye/Eye Turning	Yes	No
Eye Injury	Yes	No
Eye Surgery	Yes	No

If yes please explain _____

_____

Other _____

Past Medical History
Have you ever had any problems in
Any of the following areas:

Kidney Stones	Yes	No
Breathing Problems	Yes	No
Heart Problems	Yes	No
Pacemaker	Yes	No
Slow Heart Beat	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Fainting Spells	Yes	No
Headaches	Yes	No
Hay Fever	Yes	No
Diabetes	Yes	No
Thyroid	Yes	No
Arthritis	Yes	No
Cancer	Yes	No
AIDS/HIV Hepatitis	Yes	No
Do you drink alcohol?	Yes	No
Do you smoke?	Yes	No
Do you take drugs?	Yes	No
Are you pregnant?	Yes	No
Allergy to medicines?	Yes	No

If yes, please list:

_____

_____

Family History:
Have any blood relatives had problems
in any of the following areas:

Blindness	Yes	No
Glaucoma	Yes	No
Macular Disease	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No

Please list all current medications including eyedrops:

_____

_____

_____

_____

_____

_____

_____

Please list any previous surgery:

_____

_____

_____

_____

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