

Patient Information	
Last _____	
First _____ MI _____	
Street _____	
City _____ State _____ Zip Code _____	
Email Address _____	
Home Phone _____	
Cell Phone _____	
Work Phone _____	
Date of Birth _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Patient's SS# _____	
Employer _____	
Occupation _____	
What is the MAJOR purpose of this visit? _____	

Who may we thank for referring you to our office? (Name of friend or relative) _____	
Or how did you choose our office? _____	

Insurance Information	
VISION INSURANCE (check one) <input type="checkbox"/> VSP <input type="checkbox"/> Davis <input type="checkbox"/> Eye Med <input type="checkbox"/> Vision Care <input type="checkbox"/> VBA <input type="checkbox"/> Other	
Primary MEDICAL INSURANCE (check one) <input type="checkbox"/> Aetna <input type="checkbox"/> BC/BS <input type="checkbox"/> Cigna <input type="checkbox"/> Oxford <input type="checkbox"/> United <input type="checkbox"/> PHCS <input type="checkbox"/> Health Net <input type="checkbox"/> Medicare <input type="checkbox"/> Other	
I authorize STUDIO OPTIX to release any information to my insurance company for payment purposes. I am responsible for any unpaid balance.	
_____ Patient's signature	_____ Date
I have read the HIPPA information and understand about my record security.	
_____ Signature	_____ Date

Patient Eye History	
Date of last exam (approximate) _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind? _____	
Solutions used _____	
I am interested in <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Glasses <input type="checkbox"/> Laser Surgery	
Have you ever experienced, been diagnosed or treated for any of the following?	
<input type="checkbox"/> Blurry Vision/Eyestrain	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Eye infections	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Flash of Light	<input type="checkbox"/> Floaters/Spots
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Headaches
<input type="checkbox"/> Iritis/Uveitis	<input type="checkbox"/> Itchiness
<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Sunlight Sensitivity
<input type="checkbox"/> Tearing	<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Other eye disorders	
Patient Medical History	
Name of Family Physician _____	
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins & birth control pills) _____	

Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any eye surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you PREGNANT (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been diagnosed or treated for the following health problems	
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)	
Blindness <input type="checkbox"/>	Cataracts <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Glaucoma <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Lazy Eye <input type="checkbox"/>
Macular Degeneration <input type="checkbox"/>	Retinal Problems <input type="checkbox"/>