

Whom may we thank for referring you?

Today's Date: \_\_\_\_\_

Patient's Last Name		First Name		M.	Gender		SS#	
					Male Female			
Address			Apt#		City		State Zip	
Home Phone			Work Phone			Spouse or Parent's Name if Minor		
Employer		Occupation			Birthdate		Age	
Insurance				Insured's ID#			Primary Care Doctor	
Relationship to Insured:		Emergency Contact:				Email Address: For electronic correspondence		
Self Spouse Dependent								

**What is the reason for your visit today?**

**Last Eye Exam?** \_\_\_\_\_

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Lost or broken eyeglasses  | <input type="checkbox"/> Problems with current contact lenses | <input type="checkbox"/> Eyes feel dry                      | <input type="checkbox"/> Eyes feel tired     |
| <input type="checkbox"/> Want new contacts          | <input type="checkbox"/> Blurred distance vision              | <input type="checkbox"/> Pain in eyes                       | <input type="checkbox"/> "spots" on floaters |
| <input type="checkbox"/> I'm wearing contact lenses | <input type="checkbox"/> Blurred near vision                  | <input type="checkbox"/> Headaches                          | <input type="checkbox"/> double vision       |
| <input type="checkbox"/> disposable                 | <input type="checkbox"/> Problems with night driving          | <input type="checkbox"/> Droopy eyelid                      | <input type="checkbox"/> Sensitive to light  |
| <input type="checkbox"/> rigid gas permeable        | <input type="checkbox"/> Eyes water                           | <input type="checkbox"/> Eyes itch                          | <input type="checkbox"/> other               |
| <input type="checkbox"/> soft                       |   | <input type="checkbox"/> Changes in vision since last exam? |  |
| <input type="checkbox"/> colored                    |   | near far  |  |

**Personal Medical History: Please check all that you have now or have had in the past**

- |  |                                  |  |   |
|--|----------------------------------|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Heart Disease                       | <input type="checkbox"/> Eye Surgery      |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney  | <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Eye injuries     |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Smoking, Alcohol or Substance Abuse | <input type="checkbox"/> Retinal problems |

**Family Medical History: Check all that apply to immediate family members**

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Glaucoma                     |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Cataracts                    |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Blindness | <input type="checkbox"/> Retinal or Macular Disorders |

Computers: How many hours per day? \_\_\_\_\_ Sports: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Current Medications:	Allergies to Medications	Pregnant?
	Yes Which Ones?	No
	No	Yes #Months

**Authorization for Medical Treatment**

I request the payment of authorized medical benefits to be made to Dr. Mason on my behalf for any services furnished to me by that physician. I authorize the holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all my insurance submissions. The patient and/or responsible party agree to pay all collection, attorney and court fees that may be incurred for delinquent accounts.

Signature on File \_\_\_\_\_

Date \_\_\_\_\_