WELCOME TO OUR OFFICE

Date_____

Last name_____First name_____0_____

Address_____City_____State___Zip_____

Telephone (H)_____(W)_____(Cell)_____

E-mail Address_____

SSN_____ Date of Birth_____Dr Lic #_____State____

Male___Female___Occupation_____Employer_____

Who may we thank for referring you to our office _____

Single___Married___Other___ Other family members living at home:

Spouse_____Date of Birth_____

Name_____Date of Birth_____

Name_____Date of Birth_____

Primary Insured (if not patient) Name_____Date of Birth_____

Vision Insurance Plan_____Policy/Group Number_____

Medical Insurance Plan_____Policy/Group Number_____

I authorize release of medical information necessary to process any insurance claim and request for payment of medical benefits to the undersigned physician or supplier of service.

_____

Signature of insured party

Payment is required when services are rendered, unless prior arrangements have been made.

_____

Signature of responsible party Relationship

Medical Information

Do you have any problems with any of the following? (Circle all that apply)

Gastrointestinal	Y/N	Nervous system	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine(glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Integumentary (skin	Y/N	Allergic	Y/N

Please explain_____

Please answer all that apply:

Diabetes Y/N Type_____ Date of diagnosis_____

Allergies Y/N Allergic to what?_____

Medication allergy Y/N What happens?_____

Other health problems_____

Current medications_____

Do you use tobacco / cigarettes _____

Name of family doctor_____

FAMILY HISTORY

High blood pressure Y/N Relation _____Macular degeneration Y/N

Diabetes Y/N Relation _____Retinal detachment Y/N

Glaucoma Y/N Relation _____Cataracts Y/N

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type _____Date_____

Have you ever had an eye injury? Y/N Type _____Date_____

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred Vision? Y/N

Other eye problems? Y/N What kind?_____

Do you wear glasses? Y/N Contact Lenses? Y/N Type_____

Additional information_____

_____

HIPPA COMPLIANCE ACKNOWLEDGEMENT

I acknowledge that I have been told that at Alpert Vision Care, my personal information will not be given to anyone without my permission.

Date_____ Patient Name_____

Signature_____

Our Privacy Parctice Information is posted in our office. A copy of which is available upon request