Welcome to Our Office

For faster service, please complete prior to appointment time.

Patient's Name (please print)_________________________________ Date of Birth __________________
(As it appears on insurance card)
How would you like to be addressed? (Nickname)____
If a minor, Parent's Name(s) ____
M ☐ F ☐ SSN_______________________ Single ☐ Married ☐ Widowed ☐
Street Address ____
City_______________________________________ State________________ Zip_________________
Phone: Home______________________ Work_____________________ Cell_____________________
E-Mail _____________________________________
Employer____________________________________ Occupation________________________________

*Preferred Language: English ☐ Spanish ☐ Other__________
*Please check the most appropriate: Race: White ☐ African American ☐ Asian ☐ Pacific Islander ☐
*Please check the most appropriate: Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐ Pacific Islander ☐
*Communication Preference: E-mail ☐ Postal ☐ Telephone ☐

Spouses Name _______________________________________ Date of Birth_____________________
Emergency Contact: Name____________________________________ Phone____________________
Date of Last Eye Exam _________________________ Dr's Name ______________________________
How did you hear about our office?____

Insurance Information

Vision Insurance Carrier:___________________________________ Member ID #__________________
Insured's Name:____ Date of Birth__________________
Health Insurance Carrier:____
Member ID#______________________________Group/Policy# _________________________________
Primary Insured's Name:____________________________________ Date of Birth__________________
Do you have a secondary Health Insurance? Yes ☐ No ☐ Name:____________________________________
Member ID#______________________________Group/Policy #_________________________________
Primary Insured's Name:____________________________________ Date of Birth__________________

I request that payment of authorized Medicare benefits or the above carrier, be made to **David A. Johnson, O.D., Nancy S. Barr, O.D., Kristine B. Hopkins, O.D. or Lindsay J. Marshburn, O.D.** for any services rendered to me. I authorize any holder of medical information about me to be released to Health Care Financing Administration and its agents any information needed to determine payment for these related services. I understand my signature requests that payment be made and authorizes release of medical information and if "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of information necessary to pay the claim. I understand I am financially responsible for the deductible, co-insurance and non-covered services.

Signature______________________________________ Date_____________________________

Patient Name_______________________________________ Date of Birth_________________

Health History Information

Please check box if you have had the following:

☐ Bloodshot Eyes	☐ Blurred Vision	☐ Burning	☐ Crossed Eyes	☐ Diabetes
☐ Discharge from eyes	☐ Double Vision	☐ Dry Eyes	☐ Eye Injury	☐ Eye Strain
☐ Eye Surgery	☐ Floaters/Spots	☐ Glaucoma	☐ Headaches	☐ High Blood Pressure
☐ Itching	☐ Lazy Eye	☐ Loss of Vision	☐ Macular Degeneration	☐ Poor Color Vision
☐ Retinal Detachment	☐ Seeing Halos	☐ Seeing Flashes	☐ Seeing Flashes	☐ Watering Eyes

Do you take any medications? (Please include vitamins and/or supplements.)

Name	Dosage	Reason for Taking

If more space is needed, please use a separate sheet of paper or provide your current medication list.

Do you have any non-medication or medication allergies? Yes ☐ No ☐ If yes, please list below.

____

Name(s) of physician(s)____

Tobacco use: None ☐ Current every day smoker ☐ Current some day smoker ☐ Smokeless tobacco user ☐

If current smoker, how much?___________________________ How many years?_____________

Alcohol use: None ☐ Social ☐ 1-2 Drinks a day ☐ 3 or more a day ☐

Do you wear glasses? Yes ☐ No ☐

Do you wear contacts? Yes ☐ No ☐ Are you interested in contacts? Yes ☐ No ☐

Are you interested in laser vision correction? Yes ☐ No ☐

Family History

Please check box if anyone in your family has had the following:

☐ Cataracts	☐ Crossed Eyes	☐ Diabetes	☐ Double Vision	☐ Dry Eyes
☐ Eye Surgery	☐ Floaters/Spots	☐ Glaucoma	☐ Headaches	☐ High Blood Pressure
☐ Lazy Eye	☐ Loss of Vision	☐ Macular Degeneration	☐ Poor Color Vision	☐ Retinal Detachment

Please explain any boxes you have checked: ____

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Please sign and date below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature X____ **Date** ________________________