Welcome To The Office

Patient's Name _____ **Date** ___/ ___/ ___

If Married, Name of Spouse_____ **If Child, Parent's Name**_____

Address_____ **City**_____ **State** _____ **Zip**_____

Phone (___) _____ **Business Phone** (___) _____ **Cell** (___)_____

Email _____**Preferred Method of Contact** _____

Social Security # _____/____/_____ **D.O.B.**____/ ____/ _____ **Place of Employment / School**_____

Medical Insurance: Plan / # _____

Vision Insurance: Plan / # _____

List Activities / Hobbies that may require special vision care:_____

Are you wearing Contact Lenses? _____**Are you interested in Contact Lenses?** _____ **Last Vision Exam:** ___/ ___/ ___

Reason For Today's Visit_____

Medical Dr. _____ **Last Medical Visit** ___/ ___/ ___

How were you Referred to our office? _____

Does anyone in your family have any medical problems? _____

Does anyone in your family have any ocular problems? _____

Review of Systems	Yes	No	In Family
Allergies			
High Blood Pressure			
Heart Disease			
Diabetes			
Gastrointestinal			
Cancer			
Endocrine/Thyroid			
Ear-Nose-Throat			
Headaches			
Urinary			
Blood/Lymph Nodes			
Respiratory			

List any Medications you are currently taking?

_____

Ocular History

Blurred Vision	Yes □	No □	Eye Infections	Yes □	No □
Double Vision	Yes □	No □	Glaucoma	Yes □	No □
Tired Eyes	Yes □	No □	Tearing	Yes □	No □
Spots	Yes □	No □	Surgery	Yes □	No □
Cataracts	Yes □	No □	Trauma	Yes □	No □

I request that payment of authorized Medicare Benefits or other insurance be made either to me or on my behalf to Island Eye Care, Dr. Charles J. Turner for any services furnished me by that doctor. I authorize any holder of medical information about me, to release to the health care financing administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Lifetime Patient Signature _____ **Date** ___/ ___/ ____