

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Patient's Name _____ DOB _____ Male or Female _____
Names of parents/guardians if patient is a minor _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email Address _____
Employer _____ Occupation _____ Work Phone _____
Spouse Name _____ Emergency Contact _____ Ph. _____
Who can we thank for referring you to our office? _____

INSURANCE INFORMATION

Insurance Carrier _____ Policy # _____
Subscriber's Name _____ Subscriber's SSN/DOB _____

MEDICAL HISTORY

Your Primary Physician _____ Primary reason for today's exam _____
Age of present glasses _____ Last eye exam _____ From Dr. _____ Have your eyes ever been dilated? _____
Do you or any blood relatives have any of the following? If yes, please check box and write who and when.
 Diabetes _____ High blood pressure _____ Thyroid problems _____
 Cataracts _____ Glaucoma _____ Retinal detachment/degeneration _____
Please list any medications you are taking. _____
Please list any medications you are allergic to. _____
Have you ever had an eye infection, disease, injury, or eye surgery? Please explain. _____
Do you ever see double? No Yes When? _____ Do you have trouble with night vision? No Yes
Are you sensitive to bright light? No Yes Do you have frequent or severe headaches? No Yes When? _____
Have you ever worn contact lenses? No Yes Are you interested in new contact lenses? No Yes
Are you interested in Laser Surgery? No Yes

FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. This office will provide insurance information, but the undersigned accepts primary responsibility for all fees incurred. Permission for release of all medical and insurance information is granted. I authorize payments of medical benefits to the physician for services described. I have read the above and understand.

Patient Signature _____ Date _____

Thank you,
Douglas M. Osborne, O.D. & Staff