PATIENT INFORMATION Date____________

First Name ____________________ Middle Initial ___________ Last Name______________________

Address ______________________________ City __________________ State ______ Zip_______

Home phone(_____)____________Cell (_____)___________ Daytime # (   )_________________

Social Security# ____________________ Date of Birth _________________________ Age_________

Employer ________________________________Occupation__________________________________

If minor, parents' names_____________________ ______School_____________________________

Name & birthdates of other family members____

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Who may we thank for referring you to this office? ____

TO GIVE YOU A THOROUGH EXAM, PLEASE ANSWER THE FOLLOWING:

1. Date of last vision examination: ________Date you received your present glasses:_______________
2. Describe any problems you are having with your eyes or vision:_________________________________

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3. Describe any problems you are having with your glasses:_____________________________________

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4. Do you work with a computer? Yes _____ No____ Hours per day_________________________
5. Are you currently wearing contact lenses? No ___ Yes ___ Soft ___ Gas Permeable ___ Daily Wear ___ Extended Wear____ Disposable____
6. Are you interested in learning more about the benefits of contacts or refractive surgery? Yes No
7. ***Family*** history: Diabetes ___ Cataracts ____ Glaucoma ____ Blindness ____ Macular Degeneration ____
8. Do ***YOU*** have: Allergies ____ Sinus problems ____ Eye injury/surgery ____ High blood pressure_____ Other diseases? __ Headaches? __ Spots or floaters? __ Double vision? __ Lasik/Refractive surgery? __
9. Family physician ________________ Phone _________________ Specialist________________________
10. Have you ever had your eyes dilated? Yes _____ No ____ 11. Do you smoke? Yes____ No____

12.Medications

INSURED'S First Name **(FINANCIALLY RESPONSIBLE PERSON! PARENT)**

First Name____________________ Middle Initial _____ Last Name______________________________

Date of Birth____________ Social Security#_______________________

Vision insurance co. _____________________ Policy # _____________________ Group #_________

Medical insurance co._____________________ Policy # _____________________ Group #_________

Secondary insurance co. __________________ Policy # _____________________ Group #_________

ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to N. Ridgeville Eye Care, Inc.. I am financially responsible for non-covered services. I also authorize this office to release, any medical information deemed necessary by my insurance and have been provided its PRIVACY POLICY.

Signed (Patient, or parent, if a minor)____