RETURN PATIENTS SEEN WITHIN PAST 3 YEARS Date_____

First Name_____MI____Last Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Home Phone (____)_____Cell Phone (____)_____Okay to receive texts? Yes No

Work Phone (____)_____Occupation_____

Email Address_____Okay to receive emails? Yes No

Spouse/Guardian's Name_____

TO GIVE YOU A MORE THOROUGH EXAM, PLEASE **CIRCLE** ANY OF THE FOLLOWING PROBLEMS YOU ARE CURRENTLY EXPERIENCING:

Blurred Vision	Diabetic	Double Vision	Dry Eyes	Eye Pain/Soreness
Headaches	Itching Eyes	Red Eyes	Sandy/Gritty Feeling	Sleep Apnea
Spots/Floaters	Tired Eyes	Watery Eyes	Other_____	

Are you worried about **Cataracts**? Yes No Are you worried about **Glaucoma**? Yes No

CURRENT MEDICATIONS AND DOSAGES:_____

_____

MEDICATION ALLERGIES_____

FAMILY PHYSICIAN AND NEW HEALTH PROBLEMS SINCE LAST VISIT HERE_____

_____

INSURED NAME (FINANCIALLY RESPONSIBLE PERSON/PARENT)

First Name_____MI____Last Name_____Date of Birth_____

Social Security # (**Last 4 digits only**)_____

Vision Insurance Company _____Medical Insurance Company_____

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 minor)_____Date_____