The information in this confidential personal history form is critical to the evaluation of you vision.

Name _____ Birth Date ___/___/_____ Last Eye Exam? _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

E-mail Address _____

Employer _____ SSN __ __ __- __ __- __ __ __ __ Primary on Account _____

Do you have **VISION** insurance? No Yes If yes, which plan (circle): VSP EyeMed MES IEHP MCal Other: _____

Medical Insurance Plan _____ ID# _____ Policy # _____

How did you choose our office?

Friend/Relative (name) _____, Insurance, Yelp, Facebook, Website, Location, Other _____

Health History: Please check the conditions that apply to you or your immediate family.

Ocular History:		**Medical History:**	
Allergies	___ Self ___ Family	Cancer	___ Self ___ Family
Cataracts	___ Self ___ Family	Diabetes	___ Self ___ Family
Glaucoma	___ Self ___ Family	Hypertension	___ Self ___ Family
Lazy Eye	___ Self ___ Family	Cholesterol	___ Self ___ Family
Macular Degeneration	___ Self ___ Family	Heart	___ Self ___ Family
Retinal Detachment	___ Self ___ Family	Arthritis	___ Self ___ Family
Eye Trauma	___ Self ___ Family	Thyroid	___ Self ___ Family
		Headaches	___ Self ___ Family

Please check all that pertain to your eye history: _____ Eye Surgery ____ Contacts ____ Glasses

Please list any known **ALLERGIES TO MEDICATIONS**: _____

Please list any **PRESCRIBED MEDICATIONS** you are taking: _____

_____

Payment Terms:

We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum of 50% deposit is requested and the balance is due upon delivery. We gladly accept cash, Visa, M/C, Discover, and American Express for payment.

Please sign: _____ Date: _____