Today's Date_____ Patient Name:_____
First Last MI

Patient's Social Security #:_____ Patient's birthdate:_____/_____/_____
Month Day Year

Patient's Address:_____
Street City State Zip

Phone # _____ _____ _____
Home Work Cell

Sex: □M □F □Married □Widowed □Single □Minor □Separated □Divorced □Partnered

Email :_____ Occupation:_____ Employer:_____

Spouse's Name:_____ Spouse's Work#_____

How did you hear about our office?_____

Person responsible for this account:_____ Relationship _____

Parent (if patient is a minor): _____

Name of Vision Insurance Plan:_____ □None

Name of Major Medical Insurance:_____ □None

Subscriber's:_____ _____ _____
Name Social Security # Birthdate

Assignment and Release
I certify that I, and/or my dependent(s) have insurance coverage with the above named insurance companies and assign directly to Drs. Brockman & Tsao all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information as needed to process these claims.

We will file your insurance claim as a courtesy to you; it does not release you of your responsibility to pay all of the above charges. I agree to pay the above fees even if they are denied by my insurance carrier. X_____

Date of last eye exam:_____ Date of last medical exam:_____

Name of Doctor:_____ Name of Doctor:_____

Medications: Please list all the medications you are currently taking (including oral contraceptives, aspirin, over-the-counter medications and home remedies):
□ None

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: Please list any medications that you are allergic to: □ None

_____ _____

_____ _____

Please list any surgeries you have had:

_____

_____

□ Continue to next page

Please check any of the following that apply:

	Yourself	Family Member
Wears glasses	□yes □no	□yes □no
" contact lenses	□yes □no	□yes □no
Cataract	□yes □no	□yes □no
Glaucoma	□yes □no	□yes □no
Blindness	□yes □no	□yes □no
Lazy eye	□yes □no	□yes □no
Crossed eye	□yes □no	□yes □no
Macular degeneration	□yes □no	□yes □no
Retinal detachment	□yes □no	□yes □no
Double vision	□yes □no	□yes □no
Floaters	□yes □no	□yes □no
Flashing lights	□yes □no	□yes □no
Halos	□yes □no	□yes □no
Red eyes	□yes □no	□yes □no
Dry eyes	□yes □no	□yes □no
Watery eyes	□yes □no	□yes □no
Tired eyes	□yes □no	□yes □no

Other_____

_____

	Yourself	Family Member
Arthritis	□yes □no	□yes □no
Cancer	□yes □no	□yes □no
Diabetes	□yes □no	□yes □no
Heart disease	□yes □no	□yes □no
High blood pressure	□yes □no	□yes □no
Kidney disease	□yes □no	□yes □no
Lupus	□yes □no	□yes □no
Thyroid disease	□yes □no	□yes □no
AIDs/HIV	□yes □no	□yes □no
Hepatitis (Type___)	□yes □no	□yes □no
Headaches	□yes □no	□yes □no
Migraine	□yes □no	□yes □no
Seizures	□yes □no	□yes □no
Sinus allergy	□yes □no	□yes □no
Asthma	□yes □no	□yes □no
Bronchitis	□yes □no	□yes □no
Emphysema	□yes □no	□yes □no

Other_____

_____

Number of dependent children: _____ Number of adult children: _____ □ Check box if pregnant or nursing

Have you ever been a smoker? _____ Are you currently smoking? _____
Do you use illegal drugs □ yes □ no

Do you drink alcohol: □ no □ yes amount _____

Your primary reason for today's visit is: _____

Any additional comments you may have: _____

_____

Person to contact in case of emergency:

Name_____
Address_____
_____
Phone_____

Relationship to you_____