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

Occupation:_____ Employer:_____

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

Person responsible for this account:_____ Relationship _____

Parent (if patient is a minor): _____

Name of Vision Insurance Plan:_____ ☐ None

Subscriber's:_____ _____ _____
Name Social Security # Birth date

Name of Major Medical Insurance Plan:_____ ☐ None

Policy #:_____ Group#_____

Subscriber's:_____ _____ _____
Name Social Security # Birth date

Assignment and Release
I certify that I, and/or my dependent(s) have insurance coverage with the above named insurance company(ies) 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_____

Year of last eye exam and name of Doctor:_____ ☐ none
Year of last medical exam and name of Doctor:_____ ☐ none

Medications: Please list all the medications you are currently taking (including birth control, aspirin, over-the-counter medications, vitamins and herbals):
☐ None (or we can make a photocopy if you have a list)

Name of medication: **Reason for taking:**

_____ _____
_____ _____
_____ _____

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

_____ _____
_____ _____

☐ **Please turn page over and complete other side**

Please list any surgeries you have had: ☐ none

_____

_____

_____

Which pharmacy do you prefer : _____

Check if you or a family member have:

	self	which relative (if any)
high blood pressure	☐	_____
diabetes	☐	_____
high cholesterol	☐	_____
heart disease	☐	_____
cataracts	☐	_____
glaucoma	☐	_____
macular degeneration	☐	_____

Check if you have:

- ☐ dry eyes
- ☐ hay fever
- ☐ indigestion
- ☐ thyroid problems
- ☐ headache
- ☐ migraine
- ☐ arthritis
- ☐ shortness of breath
- ☐ recent weight loss or gain
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ HIV/ Aids

Any additional information that you would like the Doctor to be aware of:

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

When did you start smoking: ☐ never ☐ year smoking began _____ ☐ year smoking ended _____ ☐ current smoker

Do you drink alcohol: ☐no ☐ less than 1 drink per day ☐ 1-2 per day ☐ more than 3 drinks per day

How did you hear about our office?_____

Your primary reason for today's visit is: _____

_____

email address (this will only be used to confirm appointments, etc. and will never be shared):

_____

Person to contact in case of emergency:

Name_____

Address_____

_____

Phone_____

Relationship to you_____