

Please have your driver's license & health insurance cards available
ALL COPAYMENTS & FEES MUST BE PAID IN FULL
AT THE TIME SERVICES ARE RENDERED
ALL PATIENTS MUST FILL OUT THIS FORM AT EACH VISIT!

Dr Mr Mrs Miss Ms _____		DATE _____
Address _____ # _____		D.O.B. _____
City _____	State _____	Zip _____
Home _____	VISION PLAN*	
Work _____	Please circle one	
Cell _____	VSP SPECTERA SUPERIOR VBA VCP	
Email _____	BLOCK LOGISTICS BC/BS UHC MES	
Occupation _____	_____	
Employer _____	Member's Name _____	
Driver's License # _____	Member ID # _____	Member D.O.B. _____
Account # (SSN)		
<input type="checkbox"/> Check this box if you want to opt out of electronic communications.		
*Vision Plans help you with a "well eye exam." This is a non-medical exam for glasses or contact lenses only.		

ARE YOU NOW OR HAVE YOU EVER BEEN TOLD YOU'RE A DIABETIC?
PLEASE TELL US UNDER MEDICAL CONDITIONS BELOW

MEDICAL HISTORY	
Any problems that you would like to be treated for today: _____	

List any medications you are taking: _____	

Any serious medical conditions you or your family has: _____	

Any accidents, injuries, or surgeries on your eyes? _____	
Do you or anyone in your family have cataracts, glaucoma or any eye diseases? Which ones? _____	

Have you met your health insurance deductible? Yes / No	
Member Name _____	HEALTH INSURANCE**
Member ID# _____	BC/BS UHC AETNA CIGNA MEDICARE MES
Group # _____	PHCS GREATWEST HUMANA TxTRUECHOICE
**Health Insurances will cover an exam for people who have diabetes, glaucoma, and other ocular diseases. It helps cover tests that are not included in a "well eye exam."	

PLEASE CONTINUE IF WE HAVE NOT EXAMINED YOU SINCE 2008! Thanks!

GLASSES/CONTACTS	
When was your last eye exam? _____	Name of eye doctor? _____
Do you wear contacts? Yes / No Type? _____	Contacts you are interested in? _____
Who may we thank for recommending our office? _____	
Have we examined any of your friends or family? Who? _____	
