Welcome to Our Office !

DEMOGRAPHIC INFORMATION

First, Last, MI:		
Street Address:		Apt #:
City, State, Zip:		
Home Phone:	Daytime Phone:	Cell Phone:
Email:		
Preferred Contact Method: Phone Text Postal		
Patient Social Security Number:		
Date of Birth:	Male / Female	
Employer:	Occupation:	Full Time Part Time
Marital Status: Married Single Divorced Widowed		
Preferred Language: English Spanish	Ethnicity: Hispanic/Latino Not Hispanic/Latino	
Race: American Indian White Black/African American Hispanic Native Pac. Islander Asian		
Emergency Contact and Phone:	Whom May We Thank for Your Referral?	

INSURANCE INFORMATION

Vision Insurance:	Vision Insurance Member Name:
Vision Insurance Member ID #:	Vision Insurance Member Date of Birth:
Primary Medical Insurance:	Primary Member Name:
Insurance ID #:	Insurance Group #:
Primary Member Date of Birth:	Primary Member Social Security Number:
Your Relationship to Primary Member:	

I, the undersigned certify that I have insurance coverage with the above named insurer. I assign directly to Radzwill Optometric Associates, all insurance benefits payable to me for services rendered. I agree to be financially responsible for any and all of the charges not paid by my insurance company. I authorize the use of this signature on all insurance submissions. I authorize any holder of medical information about me to release my insurer and its agents any information needed to determine these benefit payable for services. I understand if my account goes delinquent past 60 days, interest will accrue at a rate of 1.5% per month on unpaid balances. If my account is given to a collection agency, I agree to pay for collection fees and associated legal fees.

Furthermore, I authorize reports of my entire medical evaluations to be sent to my referring physician and/or physician involved in my healthcare. I also authorize any physician, hospital, or medical facility to provide all information regarding my medical history and treatment.

Authorized Signature:_____

EYE HISTORY

Date of Last Eye Exam:	
Currently Wear Glasses:	How Many Hours a Day:
Currently Wear Contacts:	
Reason for Today's Visit:	
Have you had any eye surgeries since your last visit?	

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	Yes	No	Family
Cross Eye	Yes	No	Family
Glaucoma	Yes	No	Family
LASIK or RK/PRK	Yes	No	Family
Lazy Eye	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family

Are you currently experience, or have experienced, any of the following? Check all that apply.

Blurry Vision	Near or Distance
Burning	
Discharge	
Double Vision	
Dryness	
Excess Tearing / Watering	
Eye Infection	
Eye Pain or Soreness	
Floaters or Spots	
Halos	
Headaches	
Itching	
Light Flashes	
Light Sensitivity	
Redness	
Sandy or Gritty Feeling	

MEDICAL HISTORY

Date of Last Physical Exam:	
Primary Care Doctors Name:	

Have you or a family member experienced, or been treated for, any of the follow? Circle all that apply. Please name the family member.

AIDS / HIV	Me	Family:
Allergies	Me	Family:
Arthritis	Me	Family:
Asthma	Me	Family:
Blood / Lymph Disorder	Me	Family:
Cancer	Me	Family:
Diabetes	Me	Family:
Ears, Nose, Throat Conditions	Me	Family:
Gastrointestinal Conditions	Me	Family:
Heart Disease	Me	Family:
High Blood Pressure	Me	Family:
High Cholesterol	Me	Family:
Kidney Disease	Me	Family:
Lupus	Me	Family:
Neurological Conditions	Me	Family:
Psychiatric Disorder	Me	Family:
Seizures	Me	Family:
Skin Conditions	Me	Family:
Stroke	Me	Family:
Thyroid Dysfunction	Me	Family:

Current Medications:

Are you allergic to any medications?

Hobbies:	Sports:
Are You Pregnant or Nursing:	
Do You Smoke:	How Often:
Do You Drink:	How Often: