Today's Date: ____/_____/_______

Patient Information:

Title: Dr. Mr. Mrs. Ms. Last Name: ______________________________

First Name: ______________________ Middle Initial: _______ Preferred Name: ____________________

Address: ________________________________

City: _______________ State: _____ Zip: _________

May we leave a message on your phones?

Home Phone: ________________________ yes no

Cell Phone: ________________________ yes no

Daytime Phone: ______________________ yes no

May we contact you via email?

Email: ______________________________ yes no

Birth Date: ______/______/_________ Age: _________

Social Security #: ________/______/__________

Sex: M F Marital Status S M D W

Emergency Contact: ______________________________

Phone: ______________________________

If the patient is a minor:

Guardian:______________________________

Relationship to patient: ______________________________

Phone Number: ______________________________

Insurance Information:

Primary Insurance: ____________________________

ID #: ____________________________

Insured's Name: ____________________________

Date of Birth: ___/___/_____ SSN#_____/____/_______

Relationship to Insured (circle one): self spouse dependent

Employer's Name: ____________________________

Secondary Insurance: ____________________________

ID #: ____________________________

Insured's Name: ____________________________

Date of Birth: ___/___/______ SSN#_____/____/_________

Relationship to Insured (circle one): self spouse dependent

Family History Information:

Have any of your **blood relatives**, living or deceased, had any of the following conditions? (circle all yes or no)

Glaucoma	yes	no	Retinal Disease/Detach	yes	no	Diabetes	yes	no
Cataract	yes	no	Blindness	yes	no	High Blood Pressure	yes	no
Crossed Eyes	yes	no				Heart Disease	yes	no
Macular Degeneration	yes	no	Cancer	yes	no	Kidney Disease	yes	no

Referral

How did you hear about us? (circle all that apply)

Insurance list Sign/Marketing Phonebook Website Friend/Family ______________________________

Personal Medical/Ocular History Information:

What is the name of your primary care physician? ____

Medical History

Have you ever been diagnosed with any of the following: (circle all yes or no)

Diabetes	yes	no	Kidney/Liver Disease	yes	no
High Blood Pressure	yes	no	Hypo/Hyperthyroidism	yes	no
Heart Disease	yes	no	Cancer	yes	no
High Cholesterol	yes	no	Stroke	yes	no

Do you take any medications on a regular basis? **yes** **no** Please list below:

____

____

____

Do you have allergies to medications? **yes** **no** Please list :____

____

Do you smoke? yes no Do you drink alcohol? yes no Are you pregnant/nursing? yes no

Ocular History

Who performed your last eye exam? ____ When? ____________________

Have you ever been diagnosed with any of the following: (circle all yes or no)

Glaucoma	yes	no	Macular Degeneration	yes	no
Cataracts	yes	no	Retinal Disease/Detach	yes	no
Corneal Disease	yes	no	Crossed Eyes	yes	no

Have you ever had surgery on your eyes? Please list: ____

Please list all eye medications:____

What is the reason for your visit today? (mark all that apply)

Distance vision blur	yes	no	Glaucoma	yes	no
Near vision blur	yes	no	Cataracts	yes	no
New Contact lenses	yes	no	Red Eyes	yes	no
New Glasses	yes	no	Painful Eyes	yes	no

How old are your current glasses? _________________________

If you wear contacts, what brand? _________________________ Are you satisfied with them? yes no

Please list the name of any specific individuals to whom we may release personal medical/vision information:

____

____

____

Acknowledgement of Receipt of Privacy Policies

I have been presented with the Notice of Privacy Practices of Mid-State Eye Partners Inc. and have been offered a copy of the policy to keep for my records.

____

Signature of patient/guardian Date

Insurance Authorization

I request that payment for authorized insurance benefits for any services furnished me, be made on my behalf to Mid-State Eye Partners Inc.

I authorize any holder of medical information about me to be released to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that Mid-State Eye Partners Inc. makes every effort to verify the benefits provided by my insurance carrier, but the benefits expressed by Mid-State Eye Partners Inc. is no guarantee of payment by said insurance carrier. I understand that I am responsible, in full, for charges not paid by the insurance plan.

____

Signature of patient/guardian Date

Contact Lens Patient Agreement

I acknowledge that I have been properly instructed in the care of my contact lenses and understand that my failure to follow all the instructions may result in unsatisfactory service from my lenses and could result in injury to my eyes. I understand the fragility of contact lenses and that there is no warranty against damage of these lenses. Also, I have been instructed and have practiced insertion and removal of my lenses. I understand that if I experience sudden or prolonged red eyes, or prolonged irritation, I should call this office immediately.

I understand that the contact lens prescription will not be released until all progress visits are completed. The prescription is valid for replacement lenses for a period of one year. After one year, an annual contact lens examination will be required to update this prescription for replacement lenses.

I understand that each contact lens fitting fee includes all my contact lens related progress visits for a period of **45 days**.

____

Signature of patient/guardian Date