

WELCOME TO ARROW VISION

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME	FIRST	MI	<input type="checkbox"/> MALE	BIRTHDATE	AGE
			<input type="checkbox"/> FEMALE	/ /	
ADDRESS	CITY	STATE	ZIP	GUARDIAN (IF APPLICABLE)	
HOME TEL ()	REFERRED BY: _____				
WORK TEL ()	RELATIVE / FRIEND _____				
CELL/ALT. TEL ()	<input type="checkbox"/> INTERNET <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> INS. LIST <input type="checkbox"/> WALK-IN <input type="checkbox"/> OTHER				
EMPLOYER	OCCUPATION	SOCIAL SECURITY #	DRIVERS LICENCE #	EXP.	

E-MAIL ADDRESS _____

INSURANCE

1. Do you have Medical (Health) Insurance? Y N Name of plan: _____
2. Do you have Supplemental Insurance? Y N Name: _____
3. Do you have Vision (Optical) Insurance? Y N Name: VSP Eyemed Other _____

Please give your insurance cards to receptionist so copies can be made.

I hereby authorize the physician to release any information required to process insurance claims. I also authorize my insurance benefits to be paid directly to the physician and I understand I am financially responsible for non-covered services.

Signature: _____ Date: _____

PATIENT HISTORY

1. You are here for: Eye exam for glasses
 Contact lens exam Eye disease Laser surgery consult
 Other _____

2. Have you had your eyes examined in this office before? Y N

3. Last eye exam _____ from Dr. _____

4. Do you currently wear: Eyeglasses? How old? _____
 Contact Lenses? How old? _____

5. Have you worn: Eyeglasses When? _____
 Contact lenses in the past?

6. If you now wear contact lenses, fitted by _____
 Brand _____
 Gas Perm. Astigmatism Soft Color
 How often do you replace them? _____

7. What sports, hobbies do you enjoy? _____

8. Are you taking any medications? Y N
 Please list _____

9. Are you allergic to any medications? Y N
 Please list _____

10. Have you ever had an eye injury, disease, or eye surgery? Y N
 Please list _____

11. Do any immediate blood relatives have:
- | | |
|------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> macular degeneration |

Do you have or have you ever had problems in the following areas?

	YES	NO	If yes, explain.
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning / watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
flashes / floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular / retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other eye problems:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies / Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____