Patient Information

Date___/____/____ **Birth Date** ____/____/____

Patient_____

Address_____

_____

Home phone _____
Work Phone _____
Cell phone _____
Email _____
How did you hear about us? _____

_____

Communication Preference (Circle One)
Email Postal Telephone
SS#_____
Race (Circle One)
American Indian or Alaskan Native
Asian
Black or African American
Hispanic
Native Hawaiian/other pacific island
White
Ethnicity (Circle One)
Hispanic or Latino
Native Island or Other Pacific Island
Not Hispanic or Latino
Employer_____
Occupation_____
Emergency Contact Name and Phone #

_____

Marital Status _____
Parent/Spouses Name_____
Parent/Spouses SS# _____
Parent/Spouses Birth Date _____
Parent/Spouses Employer _____
Method of Payment (Please Circle)
Cash Credit Check Care Credit

Insurance Information

Insurance Co._____
Member ID#_____
Subscriber Name_____
Relationship to patient_____
Birth Date_____
SS#_____

Additional Insurance _____Yes ____No

Insurance Co._____
Member ID#_____
Subscriber Name_____
Birth Date_____
SS#_____

ASSIGMENT AND RELEASE
I, understand, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Walters all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____
Date_____

To better serve your visual needs, please answer the following: circle only answers that apply.
Do you wear any glasses? _____

_____

Do you wear contacts? _____

_____

Do you wear sunglasses? _____
Are they polarized? *Yes No I don't know*
Is safety protection a concern? *Yes No*
Do you perform fine or close-up work? *Yes No*
How much time do you spend on a computer (IPad, Smart phone, or Other LED Screen) each day?
None 1-2 hrs 6-8 hrs
Less than 1 Hr. 3-6 hrs more _____Hr.
Does computer use bother your eyes? _____
Do you have any other visual requirements for your work or hobbies?

_____

What hobbies or recreational activities do you enjoy?
Golf Hiking Sewing Biking Piano Video Games Hunting Water Sports Sports: _____
Other Activity: _____
Have you had Laser Vision Correction? *Yes No*
If not, are you interested in hearing more about laser vision correction? *Yes No*
How did you hear about us (Please Circle)
Phonebook Insurance Employer Internet
Patient Referral_____
Doctor Referral_____

Please, CIRCLE only those that apply to your <u>current</u> eye health:

Blurred distance vision
Blurred near vision
Eye strain
Poor vision
Temporary loss of vision
Eye injury
Eye infection
Discharge from eyes
Poor color vision
Routine headaches
Fainting spells
Seeing flashes
Seeing floaters or spots
Seeing halos
Double vision

Eye allergies
Itching eyes
Red/Bloodshot eyes
Burning eyes
Watering eyes
Dry eyes
Twitching eyelid
Light sensitive
Glare
Poor night vision
Macular Degeneration
Glaucoma
Other Eye Disease:
_____

Date of last Eye Exam: ___/____/____
Doctor: _____

OVER →