

PATIENT'S NAME: \_\_\_\_\_

PATIENT INFORMATION:		INSURANCE:	
Email:		Name of Insurance:	
Phone:		Insured's name:	
Address:		Insured's ID# or SS#:	
City/State/Zip:		Insured's Birth Date:	
Birth Date:	SS#:	Insured's phone:	
Occupation:		Relationship to patient:	

Main reason for today's visit: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

What TYPE of GLASSES do you wear? \_\_\_\_\_ How old are your GLASSES? \_\_\_\_\_

If you are not happy with your GLASSES, please explain the problem: \_\_\_\_\_

Are you interested in discussing LASIK VISION CORRECTION with the doctor? Yes/No

If you wear CONTACT LENSES, do you sleep in your contacts? Yes/No How often do you throw them away? \_\_\_\_\_

If you are having any problems with your contacts, please explain: \_\_\_\_\_

For NEW PATIENTS, what is your current contact lens prescription? Right: \_\_\_\_\_ Left: \_\_\_\_\_ Brand/Type: \_\_\_\_\_

Have **YOU** or any **FAMILY MEMBERS** (blood relatives only) ever been diagnosed as having any of the following? (Please check all that apply)

	Self	Family		Self	Family		Self	Family		Self	Family		Self	Family
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Eye trauma/injury	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lazy/Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

Are there any other medical conditions or eye disorders that the doctor should be aware of (please list)? \_\_\_\_\_

Please list any MEDICATIONS/SUPPLEMENTS that you take: \_\_\_\_\_

Do you have ALLERGIES to any medications, materials, or substances? Yes/No If yes, please list: \_\_\_\_\_

If you are a DIABETIC, is your diabetes currently under control? Yes/No What was your last Hemoglobin A1C Count %? \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I/We hereby grant Grand Vision Optometry and Mika E Fu O.D., Inc. to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my Insurance Company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

**CONSENT FOR TREATMENT:** I/We hereby authorize Grand Vision Optometry and Mika E Fu O.D., Inc. to administer diagnostic and medical procedures as may be necessary for proper health care.

**OFFICE POLICY ON PAYMENT:** I understand that I am responsible for payment of all charges/co-pays in full on the date of service. As a courtesy, my vision insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_