Village Optical Today's Date:______/______/______

First Name: ____________________________ M.I.:_______ Last Name:______________________________

D.O.B.:__________________ SS#:______________________

Title: Mr. Mrs. Miss Ms. Dr. Other *Marital Status:* Single Married

Address:___________________________________ **Home#**:_____________________

City:____________________________ State:_______ Zip:__________ **Work#**:_____________________

Cell#:______________________

Email:_______________________

Last Physical:_________________ Last Eye Exam:_________________

Primary Care Doctor:_____________________________

Referred By:____________________________________

Chief complaint today:____.

Do you wear glasses? **No** **Yes** If *yes*, how old is your present pair of glasses?_________

Do you wear contact lenses? **No** **Yes** If *yes*, what type?_____________________

- Do you sleep in them? **No** **Yes**
- How frequently do you replace them?____________ Are they comfortable? **No** **Yes**

List any **medications** you are currently taking (include oral contraceptives, aspirin, over the counter medications, and home remedies): ____.

Are you **allergic** to any medications? **No** **Yes** If yes, please explain:_____________________________________.

List all major **surgeries** and/or **hospitalizations** you have had:____
____.

PLEASE TURN OVER TO COMPLETE→

Family & Self History Please note any *family history,* (including yourself) for the following conditions:

	RELATION TO YOU		**RELATION TO YOU**
__ Blindness	____________________	__ Cancer	____________________

__ Cataract ____________________ __ Diabetes ____________________

__ Crossed Eyes ____________________ __ Heart Disease ____________________

__ Glaucoma ____________________ __ High Blood Pressure ____________________

__ Macular Degeneration ____________________ __ Kidney Disease ____________________

__ Retinal Detachment ____________________ __ Lupus ____________________

__ Arthritis ____________________ __ Thyroid Disease ____________________

__ Eye Injury ____________________ __ Drooping Eyelid ____________________

Are you pregnant and/or nursing? **No** **Yes**

Do you drive? **No** **Yes** If *yes*, describe any visual difficulty while driving:__________________________.

Do you use tobacco products? **No** **Yes** If *yes*, type/amount/how long:____.

Do you drink alcohol? **No** **Yes** If *yes*, type/amount/how long:____.

Any history of infectious disease? **No** **Yes** If yes, specify:____.

Vision/Medical Insurance

A **copy** of the insurance card is required on each visit.

Carrier:_________________________ Policy ID:____________________ Group ID:___________________

Card Holders or Subscribers Information: __ **Same as above or please fill in** *below* **the subscriber information.**

Name:___________________ Address:________________ City:____________ State:____ Zip:______

D.O.B:_________

I hereby authorize Village Optical to furnish information to insurance carriers concerning my examination and/or treatment and/or surgery. I hereby assign Village Optical all payments for services and materials rendered for myself or my dependant. I understand that I am responsible for any amount not covered or denied by my insurance. I hereby allow Village Optical to use my personal name and address to send postcards and billing statements.

Signature:_______________________________________

Date:__________________________