

Patient History

Patient Name: _____ Date of Birth: _____

Address: (# & street) _____ Sex: M/F Age: _____

(city, state, zip) _____ Social Security #: _____

Phone # home: _____ Family Physician: _____

Work: _____ Phone #, address: _____

Cell: _____ Email Address: _____

Age of glasses: _____ Last eye exam: _____ From Dr. _____

What are you interested today in: (check all that apply)

Routine examination __, **Glasses** __, **Contact lenses** __, **Laser Vision correction** __

Yes No

Have you been to this office before? _____

Were you referred here by anyone? friend/family/advertisement _____

Where did you hear about us. _____

Do you take any medication? _____

Please list: _____

Aspirin regularly __ Hi dose vitamins __ Antihistamines __ Birth control pills __

Are you allergic to any medications? What? _____

Do you or any family members have: Diabetes? Who? _____

Glaucoma? Who? _____

Cataracts? Who? _____

High blood pressure? Who? _____

Thyroid problems? Who? _____

Do you have frequent headaches? _____

Does sunlight or bright light bother you? _____

Do you have see double? When? _____

Do you have trouble with night vision? _____

Do you ever have flashes of light or floaters? _____

Have you ever had an eye infection, injury or surgery? _____

Do you have color vision problems? _____

Have you EVER worn contact lenses in the past? _____

Do you NOW wear contact lenses? _____

How old are you contacts? _____

How many hours/days do you wear them? _____

Type worn: Hard __ Gas permeable __ Soft __ Extended wear __ Astigmatism __ Previously fit by Dr. _____

Reason for today's visit? _____

Payment is due upon services rendered.

Present all insurance forms to the receptionist Before your examination.

NAME OF BENEFICIARY _____

HEALTH INSURANCE CLAIM NUMBER _____

I request that payment of authorized Medicare/or Medical Benefits be made either to me or on my behalf to Dr. Beja for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand fully that in the event my insurance company or financial responsible party does not pay for the services I receive, I will be financially responsible for payment. I understand that if my account is sent to collections or to any attorney, additional charges or fees may be billed at the discretion of the medical provider and added to the account on top of the billed charges for services rendered.

X _____
PATIENT'S SIGNATURE

DATE

PHYSICIAN'S SIGNATURE