

**PATIENT INFORMATION RECORD**  
**(PLEASE PRINT) (Must be reviewed each year)**

TODAY'S DATE \_\_\_\_\_ REVIEWED DATE: \_\_\_\_\_

MR. \_\_\_ MRS. \_\_\_ MISS \_\_\_ MS. \_\_\_ DR. \_\_\_ PATIENT'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ (First) (MI) (Last)  
Apt# \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE # ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ Dept./Ext. \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Work) (Pager/cell)

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PATIENT STATUS: MARRIED \_\_\_ SINGLE \_\_\_ WIDOW \_\_\_ DIVORCED \_\_\_ OTHER \_\_\_\_\_ EMPLOYED/STUDENT/RETIRED  
(Circle one)

EMPLOYER/SCHOOL NAME: \_\_\_\_\_ Occupation \_\_\_\_\_

HOW DID YOU HAPPEN TO COME TO THIS OFFICE? (CHECK ALL THAT APPLY) Yellow Pages \_\_\_ A Doctor \_\_\_\_\_

Saw our Sign \_\_\_\_\_ Insurance List \_\_\_\_\_ A Friend/Relative (name) \_\_\_\_\_ Other \_\_\_\_\_

Email Address: \_\_\_\_\_

**PATIENT MEDICAL INFORMATION**

WHAT EYE PROBLEMS ARE YOU HAVING? \_\_\_\_\_

WHEN WAS YOUR LAST EYE EXAMINATION? \_\_\_\_\_ PREVIOUS EYE DOCTOR? \_\_\_\_\_

DO YOU NOW OR HAVE YOU EVER WORN ( ) GLASSES ( ) CONTACT LENSES

ARE YOU INTERESTED IN CONTACT LENSES TODAY? ( ) YES ( ) NO

Please check box if applicable & provide details.

1. PAST EYE HISTORY: EXPLANATION: (WHEN?)  
( ) INJURY ( ) TUMOR ( ) SURGERY ( ) CROSSED EYE \_\_\_\_\_  
( ) DISEASE ( ) AMBLYOPIA(LAZY EYE) ( ) DRY EYES \_\_\_\_\_  
( ) CATARACTS ( ) RETINA PROB. ( ) GLAUCOMA \_\_\_\_\_  
( ) NO PREVIOUS INJURY/DISEASE ( ) OTHER \_\_\_\_\_

2. LIST ALL MEDICATIONS AND VITAMINS YOU ARE TAKING \_\_\_\_\_

3. ARE YOU ALLERGIC TO ANY MEDICATIONS? ( ) YES ( ) NO  
IF YES, WHICH ONES/WHAT HAPPENS? \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ Date of last visit \_\_\_\_\_

4. YOUR PAST MEDICAL HISTORY: (Check box if applicable & provide details.) EXPLANATION: (WHEN?)

( ) DIABETES ( ) SURGERY ( ) BACK/NECK DISORDERS \_\_\_\_\_  
( ) ENDOCRINE (GLANDS) ( ) NEUROLOGICAL DISORDERS \_\_\_\_\_  
( ) STROKE ( ) CANCER ( ) RESPIRATORY DISORDERS \_\_\_\_\_  
( ) HIGH BLOOD PRESSURE ( ) VASCULAR DISORDER \_\_\_\_\_  
( ) HEART DISORDERS ( ) EMOTIONAL DISORDERS \_\_\_\_\_  
( ) URINARY DISORDERS ( ) ARTHRITIS \_\_\_\_\_  
( ) THYROID CONDITION ( ) HIGH CHOLESTEROL \_\_\_\_\_  
( ) ALLERGIES ( ) OTHER ( ) HIV/AIDS \_\_\_\_\_  
( ) USE OF NICOTINE ( ) USE OF ALCOHOL ( ) OTHER DRUGS \_\_\_\_\_

RATE YOUR GENERAL HEALTH: \_\_\_\_\_

5. YOUR FAMILY EYE HISTORY: (Check box if applicable & provide details.) EXPLANATION: (MOTHER, FATHER, ETC.)

( ) GLAUCOMA ( ) DIABETES ( ) CROSSED EYE \_\_\_\_\_  
( ) EYE CANCER ( ) CATARACT ( ) RETINA PROBLEMS \_\_\_\_\_  
( ) HIGH BLOOD PRESSURE ( ) OTHER \_\_\_\_\_

**PLEASE COMPLETE INFORMATION ON BACK SIDE OF FORM**

**PATIENT INSURANCE INFORMATION**

VISION INSURANCE CO. NAME: \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ INSURED D.O.B \_\_\_\_\_

EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

IDENTIFICATION # \_\_\_\_\_ GROUP# \_\_\_\_\_ INSURED\_SSN: \_\_\_\_\_

**Vision Insurance Disclaimer:** Would you like your personal medical information shared with your vision carrier?  
YES \_\_\_\_\_ NO \_\_\_\_\_ (Recommended)

**MEDICAL INSURANCE:**

MEDICARE: \_\_\_\_\_ TRICARE: \_\_\_\_\_ MEDICAID: \_\_\_\_\_ ANTHEM: \_\_\_\_\_ CIGNA: \_\_\_\_\_ UHC: \_\_\_\_\_ AETNA: \_\_\_\_\_  
OTHER INSURANCE: \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ POLICY # \_\_\_\_\_ INSURED D.O.B. \_\_\_\_\_

**WHO IS RESPONSIBLE FOR THE PATIENT DUE BALANCE?**

Relationship to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_

**(REQUIRED IF PATIENT IS UNDER 18 YEARS OF AGE OR SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE)**

NAME: \_\_\_\_\_  
(First) (MI) (Last)

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK/CELL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

**PATIENT'S/INSURANCE AUTHORIZATION AND ASSIGNMENT**

I authorize Drs. Seim and Batac to furnish information to insurance carriers including Social Security Administration or its intermediaries of carrier, concerning my illness and treatment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts assignment. I understand that my insurance is a contract between me and my insurance carrier. I UNDERSTAND THAT I AM RESPONSIBLE FOR THIS ACCOUNT. I understand that if Drs. Seim, and Batac do not receive a response from my insurance company within 60 days of filing my claim, I am responsible for payment of this account in full. I understand that I am responsible for any amount not covered by insurance. In the event that my check is returned for non-sufficient funds, I agree to pay a \$35.00 fee. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment.

**X**

(DATE)

(PATIENT/GUARANTOR)

(RELATIONSHIP TO PATIENT)

**THIS OFFICE MAINTAINS YOUR PATIENT RECORDS FOR AT LEAST 5 YEARS FROM LAST DATE OF PATIENT ENCOUNTER. AFTER THAT TIME, THIS OFFICE MAY DESTROY YOUR RECORDS IN A MANNER WHICH PROTECTS PATIENT CONFIDENTIALITY.**