PATIENT INFORMATION

LAST NAME _____

FIRST NAME _____ MI _____

ADDRESS _____

APT # _____ CITY _____

STATE _____ ZIP _____

PHONE NUMBERS	CELL	HOME	WORK
PRIMARY			
SECONDARY			

EMAIL ADDRESS _____

OCCUPATION _____

EMPLOYER _____

SOCIAL SECURITY # _____

BIRTH DATE _____ AGE _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

☐ MALE ☐ FEMALE

COMMUNICATION PREFERENCE

☐ TEXT ☐ MAIL ☐ PHONE ☐ EMAIL

REFERRED BY _____

SPOUSE'S NAME _____

IF CHILD, PARENTS' NAMES _____

EMERGENCY CONTACT _____

PHONE _____

RESPONSIBLE PARTY

☐ **SAME AS ABOVE**

LAST NAME _____

FIRST NAME _____ MI _____

ADDRESS _____

APT # _____ CITY _____

STATE _____ ZIP _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

EMAIL ADDRESS _____

OCCUPATION _____

EMPLOYER _____

SOCIAL SECURITY # _____

BIRTH DATE _____ AGE _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT _____

All charges are expected to be paid at the time of service. A $25.00 fee is charged on all return checks. Amounts over 30 days will be charged interest at 1.5% per month with a minimum charge of $1.00 per month. Should collections become necessary, the responsible party agrees to pay an additional 33.3% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

RACE

☐ American Indian

☐ Asian

☐ Black or African American

☐ White

☐ Decline to Specify

ETHNICITY

☐ Hispanic or Latino

☐ Not Hispanic/Latino

☐ Decline to Specify

PREFERRED LANGUAGE

☐ ENGLISH

OTHER

INSURANCE INFORMATION

We MUST have a copy of your insurance cards!

VISION INSURANCE CARRIER

☐ **VSP** ☐ **SPECTERA** ☐ **NONE**

INSURED NAME _____

BIRTHDATE _____

RELATIONSHIP TO PATIENT _____

LAST 4 DIGITS OF SOCIAL SECURITY # _____

MAJOR MEDICAL INSURANCE CARRIER

_____

NAME OF INSURANCE COMPANY

INSURED NAME _____

BIRTHDATE _____

RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # OF MEMBER _____

SECONDARY INSURANCE CARRIER

_____

NAME OF INSURANCE COMPANY

INSURED NAME _____

BIRTHDATE _____

RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # OF MEMBER _____

I request that payment of insurance benefits be made on my behalf to Dr. William J. Bogus. I authorize any holder of medical information about me to release any information needed to determine those benefits payable for related services. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf and of my dependents.

_____

Signature Date

PLEASE FILL OUT OTHER SIDE !

MEDICAL HISTORY

Date of last eye exam: _____ Date of last medical exam: _____

Previous eye doctor: _____ Name of general physician: _____

Select any of the following medical conditions that you currently have:

☐ Anxiety	☐ COPD	☐ Hearing Loss	☐ Hyperthyroidism
☐ Arthritis	☐ Coronary Artery Disease	☐ Hepatitis	☐ Hypothyroidism
☐ Asthma	☐ Depression	☐ High Cholesterol	☐ Irregular Heartbeat
☐ Bone Marrow Transplant	☐ Diabetes	☐ HIV / AIDS	☐ Kidney Disease
☐ BPH	☐ GERD	☐ Hypertension	☐ Seizures
☐ Cancer (please specify) _____			☐ Stroke
☐ Other: _____			

List any past surgeries with approximate dates:

_____ _____

_____ _____

List all your medications (prescription and over-the-counter)

Medication	Strength	Medical Issue	Medication	Strength	Medical Issue

	YES	NO	
Do you smoke?	☐	☐	If so, how much? _____
Do you drink alcohol?	☐	☐	If so, how much? _____
Do you use other substances?	☐	☐	If so, how much? _____

List allergies to medications and other substances _____

Do you have any of the following?

	YES	NO
Dry Eyes	☐	☐
Blurred Vision	☐	☐
Eye Injuries	☐	☐
Eye Surgeries in Past	☐	☐
Wear Glasses	☐	☐
Wear Contact Lenses	☐	☐

Is there a family history of the following?

	Grandmother	Grandfather	Mother	Father	Sibling
Diabetes	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐

Are you currently experiencing any eye problems? _____

Please sign below to agree that you have reviewed all the information above and it is correct to the best of your knowledge.

SIGNATURE: _____ **DATE:** _____