WELCOME TO OUR OFFICE!

To help us serve you efficiently, please answer this questionnaire as completely as possible. All information is confidential.

PATIENT INFORMATION

NAME		•	DATE			
Last ADDRESS	First	M				
CITY		STATE	ZII			
PHONE:	BIRTH DATE_		AGE	SEX: M F		
CELL PHONE #:	EMAIL ADDRESS:					
Dependent/MinorSingle	Married	Divorced	Separated	Widowed		
SOCIAL SECURITY #:		DRIVER'S L	[CENSE #:			
EMPLOYER	OCCUPATION					
EMPLOYER ADDRESS			PHONE	#:		
RESPONSIBLE P	ARTY/PARENT	'INFO IF PATI	ENT IS A MI	NOR		
Name of person/parent responsible for the	ne account					
Relationship to patient	Birth date					
Address	City/State					
ZipPhone	Cell Phone					
Social Security #	Driver's License #					
	INSURANCE II	NFORMATION				
VISION Insurance Name			Phone			
Subscriber's Name	DOB					
Social Security # or ID#:	Group #:					
MEDICAL Insurance Name			Phone			
Subscriber's Name	DOB					
Social Security # or ID#:			Group #:			
	AUTHOR	RIZATION				
I have reviewed the information on this que company to pay the doctor all the insurance signature on all insurance submissions. I a benefits. I understand that I am finsurance. I understand payment is arrangements have been made.	ce benefits otherwise pauthorize the doctor to nancially responsib	ayable to me for serv release all information le for all charges	ices rendered. I au on necessary to sec whether or no	thorize the use of this cure the payment of the payment of the paid by my		

SIGNATURE

Date_

PATIENT VISUAL AND HEALTH INFORMATION

(Parent/Guardian - Please complete for minor)

Name	- 	Dr. Milanià Mapher Philaspe Flambe desimple district	Date			
Date of last eye exam	Dr.'s r	lame				
List any medications you currently take (Rx and over-	the-cour	nter):	كالموادي والمواد والمعاول والمواد والمعاول والمواد وال			
Do you have allergies to any medications? YES If YES, list the medications:	NO	ii dieniste diploire tradition applicate apparatus.	بالمراب يحارب بحارث بالمحد المهام فيها فيها المراب فيناه فيها والبواد مناس بالمدن المراب بحارث بالمراب بالمراب بالمراب بالمراب بالمراب بالمراب المراب والمراب والمراب بالمراب بالمراب والمراب والمراب بالمراب بالمراب والمراب			
List all major illnesses (glaucoma, diabetes, high blood etc.):	pressu	re, heart a	ttack, etc. or injuries (concussion,			
List any surgeries you have had (cataract, appendect	omy, etc					
Do you currently have any problems in the following a	reas? If	YES, pleas	se provide additional information.			
	YES	NO	Details			
EYES (poor vision, eye pain, tearing, redness, etc.)						
GENERAL (fever, heat stroke, weight loss, weight						
gain, unusually tired)						
EARS, NOSE, THROAT (hard of hearing, stuffy nose,						
earache, cough, dry mouth, etc.)						
CARDIÓVASCULAR (high BP, racing pulse, etc.)						
RESPIRATORY (congestion, wheezing, short of breath,						
etc.)						
GASTROINTESTINAL (stomach upset, diarrhea,						
constipation, hernia, ulcers, etc.)						
KIDNEY, BLADDER (painful urination, frequent						
urination, yellow jaundice, etc.)						
FEMALES Are you pregnant? Nursing?	**************************************					
MUSCLES, BONES, JOINTS (joint pain, stiffness,						
swelling, cramps, arthritis, etc.)						
		3				
SKIN (acne, warts, growths, rash, etc.)						
NEUROLOGICAL (numbness, headache,						
seizures, paralysis, etc.)						
PSYCHIATRIC (anxiety, depression, Insomnia)						
ENDOCRINE (diabetes, hypothyroid, etc.)						
BLOOD/LYMPH (bleeding, anemia, etc.)						
ALLERGIC/IMMUNOLOGIC (sneezing, swelling,						
redness, itching, hives, lupus, HIV/AIDS, etc.)						
FAMILY HISTORY			(Mother, Father, Grandparent, Sibling)			
Has any member of your family had these diseases (d		• • • • • • • • • • • • • • • • • • • •				
Blindness, Cataract, Glaucoma, Diabetes, Hypertens Other heritable disease:			z, outone, carrock, improve proceso, municip			
SOCIAL HISTORY						
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO						
Have you ever had a blood transfusion? YES	N()				
Do you drink alcohol? YES NO If YES, how much?						
Do you smoke? YES NO If YES, how much			How many years?			
EMERGENCY CONTACT INFORMATION						
Name of person to contact in case of emergency	ng appendix annowal months of the party desired.	من محمد المحمد الم	، مادوان خوابان وسدن والوان والحواز والوان والواز			
Address	الله والمعالمة والمع والمعالم والمعالم و	-della -della della dell	التراية التعليم والماراة والمداح والماراة والمداحة والمداحة والماراة والمداحة والمداحة والماراة والماراة والمداحة والماراة والمداحة والماراة وا			
hone # Relationship						
Whom may we thank for referring you?						
I have reviewed the information on this questionnaire						
that this information will be used by the doctor to he						
C: was a de sua a			(Guardian/Darant) Data			
SignatureSignature	الله کادمینه خواهد استان رادیمی میاساند برود	الباعدة حالياتات والماليات المالياتات والماليات أبارات أن الماليات والماليات	(Guardian/Parent) Date			