EYE PLACE OPTOMETRY
PATIENT INFORMATION FORM

EXAM DATE: _____

LAST NAME _____ FIRST NAME _____ ☐ M ☐ F BIRTH DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____ CELL PHONE ( ) _____

EMPLOYER _____ OCCUPATION _____

REFERRED BY _____ EMAIL ADDRESS _____

INSURANCE INFORMATION:

INSURANCE CO _____ PLAN NAME _____ GROUP _____

INSURED NAME _____ RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD

INSURED ID # _____ INSURED DATE OF BIRTH _____

INSURED SS # (LAST 4 DIGITS) _____ PATIENT SS # (LAST 4 DIGITS) _____

OCULAR AND MEDICAL HISTORY:

REASON FOR TODAY'S EXAM _____

AGE OF GLASSES _____ AGE OF SUNGLASSES _____ DATE OF LAST EYE EXAM _____ FROM DR. _____ PREVIOUS PATIENT? ☐ YES ☐ NO

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES	☐	☐	☐	GLAUCOMA	☐	☐	☐	DO YOU SEE DOUBLE?	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	CATARACTS	☐	☐	☐	FREQUENT HEADACHES?	☐	☐
THYROID PROBLEMS	☐	☐	☐	RETINAL DISEASE	☐	☐	☐	BRIGHT LIGHTS BOTHER YOU?	☐	☐
HEART DISEASE	☐	☐	☐	EYE SURGERY	☐	☐	☐	ARE YOU PREGNANT?	☐	☐
ASTHMA	☐	☐	☐	EYE INJURY	☐	☐	☐	EYES BEEN DILATED?	☐	☐
CANCER	☐	☐	☐	OTHER_____	☐	☐	☐	YEAR? _____		

PLEASE EXPLAIN ANY POSITIVE FINDINGS: _____

ARE YOU TAKING ANY EYEDROPS? PLEASE LIST: _____

ARE YOU TAKING ANY OTHER MEDICATIONS? PLEASE LIST: _____

DO YOU HAVE ANY ALLERGIES, MEDICATION OR OTHER? PLEASE EXPLAIN _____

CONTACT LENS INFORMATION

	YES	NO	
DO YOU WEAR CONTACT LENSES NOW?	☐	☐	IF YES, WHAT TYPE? _____
HAVE YOU EVER WORN CONTACT LENSES?	☐	☐	IF YES, WHAT TYPE? _____
ARE YOU INTERESTED IN NEW CONTACT LENSES?	☐	☐	IF YES, WHAT TYPE? _____

AUTHORIZATION STATEMENT

Please be advised that you are financially responsible for all fees and charges regardless of insurance coverage. At your request, we will bill your insurance if you provide complete, accurate insurance information along with a signed insurance claim form and/or copy of your insurance card.

I hereby authorize Eye Place Optometry / Dr. Kosol Vipapan to furnish information to insurance carriers concerning my conditions and treatments. I also assign to Eye Place Optometry / Dr. Kosol Vipapan all payments for optometric services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by my insurance.

We care about our patient's privacy and strive to protect the confidentiality of your medical information.

I have received a copy of notice of privacy practices.

Patient's Signature: _____ Date: _____
(Guardian, if patient is under 18)