

WELCOME! Thank you for choosing our practice for your eyecare needs.
Please ask us if you need any assistance completing this form.

PATIENT INFORMATION

Full Name _____ Age _____ Sex _____ Race _____ Date _____
Address _____ City _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Birthdate _____ Marital Status _____ E-Mail _____
SS # _____ Occupation _____ Employer/City _____
Family Physician _____ City _____ Phone _____
Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY/INSURANCE INFORMATION

Name of person responsible for this account (if not patient) _____
Relationship to patient _____ Address (if different) _____
City _____ Zip Code _____ - _____ Home Phone _____ Work Phone _____

Vision Insurance _____	Medical Insurance _____	Secondary Insurance _____
ID # _____	ID # _____	ID # _____
Member _____	Member _____	Member _____
Insured's Birthdate _____	Insured's Birthdate _____	Insured's Birthdate _____
Relationship to patient _____	Relationship to patient _____	Relationship to patient _____

**PLEASE PRESENT INSURANCE CARD(S).

EYE / HEALTH HISTORY

Reason for today's examination _____
When was your last eye exam? _____ Previous Eye Dr.'s name _____
Do you currently wear eyeglasses? _____ Contact lenses? _____ Interested in LASIK? _____
Do you have special visual needs for occupation or hobbies? _____
Have you had any previous history of eye injury, infection, or surgery? _____
Do you suffer from eye dryness, irritation, itching, or burning? _____
Are you currently under the treatment of a physician for any reason? _____
Medications _____
Allergy to medications _____ Do you use cigarettes/tobacco? _____
Have you or any family member (genetic relative) had a history of the following?:
Diabetes _____ High Blood Pressure _____ Thyroid _____
Headache _____ Heart Trouble _____ Sinusitis _____
Cataracts _____ Retinal Problems _____ Glaucoma _____
Allergies _____ Turned/Lazy eye _____ Blindness _____

*I certify that I have read the above information and have accurately answered the questions to the best of my knowledge. I authorize Bogan Eyecare Center to release any information from the medical records of me or my dependent to third party payers and/or other health care providers. I authorize and request my insurance company to pay benefits directly to the doctor. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

PATIENT SIGNATURE _____ DATE _____