SMITH VISION CARE LLC

PATIENT'S NAME:_____

PATIENT INFORMATION: *(NEW PATIENTS, or for ESTABLISHED PATIENTS only if your contact information has CHANGED)*	**INSURANCE:** *(NEW PATIENTS, or for ESTABLISHED PATIENTS only if your insurance has CHANGED)*
Email:	Name of Insurance:
Phone:	Insured's name:
Address:	Insured's ID# or SS#:
City/State/Zip:	Insured's Birth Date:
Birth Date: SS#:	Insured's phone:
Occupation:	Relationship to patient:

Main reason for today's visit: _____

What TYPE of GLASSES do you wear? _____ How old are your GLASSES? _____

If you are not happy with your GLASSES, please explain the problem: _____

Are you interested in discussing LASIK VISION CORRECTION with the doctor? Yes/No

If you wear CONTACT LENSES, do you sleep in your contacts? Yes/No How often do you throw them away? _____

If you are having any problems with your contacts, please explain:_____

For NEW PATIENTS, what is your current contact lens prescription? Right: _____ Left: _____ Brand/Type:_____

Hobbies:_____ Referred by:_____

*Have **YOU** or any **FAMILY MEMBERS** (blood relatives only) ever been diagnosed as having any of the following? (Please check all that apply)*

	Self	*Family*		*Self*	*Family*		*Self*	*Family*		*Self*	*Family*		*Self*	*Family*
Glaucoma			*Blindness*			*Eye Trauma Injury*			*Diabetes*			*High Blood Pressure*		
Cataract			*Retinal Disease*			*Lazy/Crossed Eyes*			*Autoimmune Disorder*			*Heart Disease*		
Macular Degeneration			*Corneal Disease*			*Thyroid Disease*			*Cancer*			*High Cholesterol*		

Are there any other medical conditions or eye disorders that the doctor should be aware of (please list)?_____

Please list any MEDICATIONS/SUPPLEMENTS that you take: _____

_____

Do you have ALLERGIES to any medications, materials, or substances? Yes/No If yes, please list: _____

If you are a DIABETIC, is your diabetes currently under control? Yes/No What was your last Hemoglobin A1C Count %? _____

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby grant New Optix Optometry to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my Insurance Company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT: I/We hereby authorize Smith Vision Care to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges/co-pays in full on the date of service. As a courtesy, my vision insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Signature: _____ **Date:**_____