

BEAVER DAM EYE CARE PATIENT INFORMATION

Name _____ Today's Date _____
Address _____ Birth Date _____ Age _____

Home Phone _____

Cell Phone _____
Email _____ Work Phone _____
Occupation _____ Employer _____
Emergency contact/telephone _____
Policy Holder/Responsible Party _____ Birth Date _____

What is your reason for seeking vision care at this time? _____

Last Eye Exam _____ When is the last time your eyes were dilated? _____
Do you wear contacts? Yes / No Are there times you'd like to wear contacts? Yes / No

HEALTH HISTORY

Name of family doctor? _____ Date of last tetanus shot _____
Do you have or have you had any of the following?

_____ asthma _____ head injury _____ glaucoma
_____ cancer/tumor _____ headaches _____ cataracts
_____ cholesterol high _____ alcohol use _____ eye infection
_____ diabetes _____ tobacco use _____ eye surgery
_____ high blood pressure _____ seasonal allergies _____ spots/ flashes of light
_____ medication allergies _____

CURRENT MEDICATIONS _____

FAMILY HISTORY

Has anyone in your family had any of the following?... (If so, whom?)

_____ diabetes _____ glaucoma
_____ cancer _____ macular degeneration
_____ heart disease _____ retinal disease/detachment
_____ high blood pressure _____ cataracts

How did you hear about Beaver Dam Eye Care?

PATIENT FINANCIAL RESPONSIBILITY

I AUTHORIZE BEAVER DAM EYE CARE TO BILL MY INSURANCE COMPANY FOR CHARGES PERTAINING TO MY CARE. I AGREE TO ASSUME RESPONSIBILITY OF FULL PAYMENT PENDING ANY REMAINING BALANCE THAT IS NOT COVERED BY MY INSURANCE CARRIER.

Patient/Guardian Signature _____ **Date** _____