Patient Information - Please Print

Patient's name:	DOB: Age:
Address:	Home Telephone:
City State ZIP:	Day/Work Telephone:
Primary Insurance:	2nd Insurance:
Employer:	Occupation:
If patient is under age 18, Parent/Guardian Name:	
Email:	Date of Last Exam:

INSURANCE INFORMATION:
Insurance Company: _____ ID#: _____ Group #: _____
Subscriber Name: _____ Date of birth: _____
Is patient covered by additional insurance? Yes No

ASSIGNMENT: I, the undersigned, certify that I, or my dependent, have insurance coverage with the company(s) listed above. I assign all insurance benefits directly to Victorian Eye Care. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____
Responsible Party Signature Relationship to Patient Date

DILATION:
In order to assure the highest level of eye health examination, the doctors recommend either dilation of the eyes or our Optomap retinal exam be performed. Please indicate which you would prefer:

___ I prefer my eyes be dilated (no additional fee)
___ I prefer the Optomap Retinal Exam
___ I prefer neither at this time – requires patient initials: ___

HEALTH HISTORY Physician's (PCP) Name _____ Last Visit _____
Please indicate if you or a blood relative has had any of the following:

You	Relative		You	Relative	
☐	☐	Allergies	☐	☐	Heart Condition
☐	☐	Arthritis	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	High Cholesterol
☐	☐	Cataracts	☐	☐	Lazy Eye
☐	☐	Diabetes	☐	☐	Macular Degeneration
☐	☐	Drug Sensitivity	☐	☐	Migraine Headache
☐	☐	Eye Injury	☐	☐	Psychiatric Disorder
☐	☐	Eye Surgery	☐	☐	Retinal Disease
☐	☐	Glaucoma	☐	☐	Skin Conditions
☐	☐	Headache	☐	☐	Thyroid Conditions

Do you have any medical conditions not listed above: No Yes
Do you use tobacco: No Yes: ___/day Do you use alcohol: No Yes: occasionally daily
List any medications you currently use (including supplements, vitamins, etc): _____
List any allergies to medications: _____
Your reason for today's visit:

PRIVACY INFORMATION
We want our patients to know that we have a privacy policy in place for your protection. You have the right to review the Notice of Privacy Policy. It is posted in our waiting area. I acknowledge that I have read (or been given the opportunity to read) the Notice.

Signature: _____ Date: _____