Name_____**Insurance** _____ **DOB**_____ **Date** _____

Preferred_____

Update Contact Information

Mobile Phone (_____)_____-_____

Email Address _____

Home Address _____

_____

Occupation _____

We use an automated reminder/notification system. To ensure you receive these messages, we assume that your mobile number is the preferred contact. If you wish to opt out please write "Opt out" below. We will not use your number to solicit or spam.

MEDICAL HISTORY

Are you pregnant/nursing now? □ Yes □ No

CURRENT MEDICATIONS (Rx and non-Rx, including drops, vitamins and birth control):

_____

_____

_____

ALLERGIES TO MEDICATIONS:

_____

_____

Have you ever been diagnosed with or treated for any of the following health problems, disorders or diseases?

□ Allergies
□ Arthritis
□ Asthma
□ Blood/lymphatic
□ Cancer
□ Eczema/rashes
□ Fatigue
□ Sudden weight changes
□ Diabetes (year diagnosed: _____)
□ High blood pressure
□ Muscle/bone
□ Neurological
□ Psychological
□ Respiratory
□ Sinus
□ Thyroid
□ Melanoma

Other _____

EYE HISTORY

Do you currently wear contacts? □ Yes □ No
□ Soft □ Rigid/hard

Do you experience any of the following?

□ Blurred vision
□ Recurrent infections
□ Flashes of light
□ Frequent headaches
□ Itching
□ Dryness
□ Trouble seeing at night
□ Burning
□ Double vision
□ Floaters/spots
□ Grittiness
□ Tearing
□ Light sensitivity
□ General discomfort

Other _____

Are any of the following conditions present in any members of your family (blood relatives only)?

□ Blindness
□ Diabetes
□ Hypertension
□ Macular degeneration
□ Corneal problems
□ Glaucoma
□ Cataract
□ Retinal problems

Other _____

AKNOWLEDGEMENT OF FINANCIAL AND PRIVACY PRACTICES

"We are happy to bill your insurance for you if we can. However, the remaining balance after any insurance benefits are applied will remain your responsibility. Overdue balances will be sent to collections unless you arrange payment options with us in advance. In the event that you have a credit balance, you will receive a prompt refund for all balances over $25 and a credit to your account for all others, unless requested in writing. Payments by check that are returned as Insufficient Funds will be charged $40 for processing."

"I am familiar with the above financial guidelines and the patient privacy practices for In Focus Eye Center, P.C."

Signed:_____

Date: _____

If patient is a minor, please sign above to indicate you give permission to treat the patient today and print your name here:_____