PATIENT INFORMATION

Patient Name _____ Birth Date _____

Employer/ School _____ Occupation _____

Work Phone _____ SSN _____

Email _____

If a minor, Parent/ Guardian _____ Birth date _____

SSN _____ Email _____

Cell Phone _____ Work phone _____

PATIENT HISTORY

Do you have or have you had...? Check if yes.

___ sinus problems	___ multiple sclerosis	___diabetes	___ eye surgery
___ heart disease	___ muscle condition	___ blood/lymph	___ eye injury
___ high blood pressure	___ skin condition	___ allergies	___ glaucoma
___ asthma	___ frequent headaches	___ drug allergies	___ spots or light flashes
___ kidney	___ head injury	___ tobacco use	___ discharge from eyes
___ bladder	___ depression	___ cataracts	___ red eyes
___ arthritis	___ thyroid disease	___ macular degeneration	___ eye irritation
___ digestive condition	___ cancer/tumor	___ other eye disease	

Explanation of above, or other eye or health problems: _____

_____

_____

_____

FAMILY HISTORY

Have any of your close blood relatives had...? If so, whom?

____ diabetes _____

____ heart disease _____

____ high blood pressure _____

____ glaucoma _____

____ cataracts _____

____ blindness _____

other eye problem _____

Are you under a physician's care or regularly taking any medications? _____ yes _____ no

List conditions and medications. _____

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Ellender/Budget Optical and Dr. Moriarty *'s* Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

If signing for patient, print name and relationship to patient _____

INSURANCE AUTHORIZATION

Patient Name _____ Birth Date _____

Insurance Co. _____

Policy Holder (name on card) _____ DOB _____

Policy Holder SSN _____ Policy ID # _____

Employer/ Insurance Sponsor _____

I hereby authorize the release of any medical or other information necessary to determine benefits payable by my insurance carrier. I request that payment of these benefits be paid to Dr. Ellender or Dr. Moriarty. I understand that I am responsible for any amount not covered by my insurance.

Signature _____ Date _____

ALL FEES THAT ARE PAIENT'S RESPONSIBILITY ARE DUE AT THE TIME OF SERVICE _____

We appreciate the opportunity to serve you!