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Welcome To Our Office

Name ________________________________ Date of birth ___________ Date____________
Address______________________________ City ______________ State____ Zip_________
Home Phone _________________ Cell Phone_______________ Work Phone _____________
E-Mail _______________________Social Security______________ Occupation____________
Employer _____________________**Vision Insurance/ policy holder** ________________
Member ID ___________________**Member DOB**_________ Relationship_______________

Chief reason(s) for visit.______________________________
Do you currently wear glasses? Yes or No
Do you currently wear contacts? Yes or No if not, are interested in wearing contacts? Yes or No
What Hobbies do you have?____
What Outdoor activities do you do?____
Are you interested in laser vision correction? Yes or No
Do you have any **Blurred Vision, Itching, Tearing, Burning, Red Eye, Glaucoma, Dryness, Flashes of Light or Spots? (Please Circle)**
Are you pregnant or nursing? _________________________
How were you referred to us? _________________________
Have you had any eye surgery? ____

Patient Medical History
Do you have any medical conditions? ____
Please list any medications: ____
Are you allergic to any medications?____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic/immunologic	Yes/No
Respiratory	Yes/No	Headaches	Yes/No	Integumentary (skin)	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain ____
Do you use any of the following: Tobacco, Alcohol, Drugs, N/A

***Please circle any *family history* for the following**:
Blindness, Cataracts, Glaucoma, Lazy eye, Poor color vision, Macular Degeneration, Turned eye.

I authorize payment of benefits to be made directly to Dr. James Sinoway.
I understand and agree that, regardless of my insurance status,**(eg; deductible not met, Referral not provided, etc.)** I am ultimately responsible for the balance of my account for any services rendered.
**Please understand that eyewear is customized to each patient, therefore only store credit will be issued for returns or exchanges. Thank you.

All insurance information is patient responsibility and must be given PRIOR to exam date or itemized receipt will be given to patient to submit. We cannot back bill your claims.
~Thank You~

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***I acknowledge that I have read & understand Dr. James Sinoway's Notice of Privacy Practices*.**

Signature ______________________________ Date____________