

Last name _____ First name _____ MI _____ Male Female

Address _____ City, State, Zip _____

SSN _____ - _____ - _____ Date of Birth (mm/dd/yyyy) ____/____/____ Driver's License # _____

Telephone (H) _____ (W) _____ (C) _____

Occupation/Employer _____ Email _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Vision Insurance _____ Health Insurance (Medical) _____

Policy holder's name & DOB _____ Relation to patient _____

Policy holder's SSN _____ - _____ - _____ Policy holder's employer _____

PERSONAL EYE INFORMATION

Date of last eye exam _____

Have you had any eye surgeries and/or injuries? Y / N Type _____ Date _____

Do you have Glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Blurred Vision? Y / N Itchy Eyes? Y / N

Other eye problems? Y / N What kind _____

Do you wear glasses? Y / N Contact Lenses? Y / N What type: Soft Hard Toric Bifocal CL Brand _____ Solution _____

MEDICAL INFORMATION

Name of primary physician _____ Phone _____ Last visit _____

Do you have any problems with any of these systems? (please circle all that apply)

Allergic/Immunologic	Y	N	Ears/Nose/Throat	Y	N	Genitourinary	Y	N	Musculoskeletal	Y	N
Blood/Lymph	Y	N	Endocrine (glands)	Y	N	Integumentary (skin)	Y	N	Nervous	Y	N
Cardiovascular	Y	N	Gastrointestinal	Y	N	Mental	Y	N	Respiratory	Y	N

Diabetes Y / N Type _____ Date of Diagnosis _____

Allergies Y / N To what? _____ Medication allergies Y / N To what? _____

Other health problems _____

Current medications _____

Have you had any surgeries? Y / N Kind _____ When _____

Do you smoke cigarettes / tobacco? Y / N Do you consume alcohol? Y / N Drink socially? Y / N

FAMILY HISTORY

High blood pressure	Y	N	Relation _____	Macular degeneration	Y	N	Relation _____
Diabetes	Y	N	Relation _____	Retinal detachment	Y	N	Relation _____
Glaucoma	Y	N	Relation _____	Cataracts	Y	N	Relation _____

Other eye conditions Y / N What kind? _____

Payment Authorization -- I authorize payment of all vision benefits for services and/or materials rendered *directly* to the doctor or provider as indicated. I understand that I am responsible for any payment not covered by the insurance plan and that services rendered and materials dispensed are not refundable. I also hereby authorize the release of information regarding my medical and vision history for the purpose of validating and determining benefits payable in connection with the insurance claim. _____ Patient's Signature (or Guardian)

Notice of Privacy Practices. I have had the opportunity to review Dr. Pablo A. Suarez P.A. & Associates' Notice of Privacy Practices. I **do / do not** (please circle one) choose to have a copy of the Notice of Privacy Practices. _____