

Welcome to our office!

Patient Name _____

If Patient is a minor, who is responsible? _____

Please list any other family members who are patients here. _____

How did you hear of our practice? _____

- Pt referral Whom may we thank for referring you? _____
 Yellow Pages Red or Yellow? (circle one)
 Insurance plan Location
 Doctor referral Other _____

Occupation? _____

Employer/School _____

Patient Birth date ___/___/___ M F e-Mail address _____

Mailing Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____

Vision Insurance Company _____

Patient ID # (if none, use SS #) _____

Whose Insurance is this? _____

Subscriber ID# or SS# _____

How is patient related? Self Spouse Child (circle one)

Secondary or Medical Insurance Company _____

Whose Insurance is this? _____

Subscriber ID# or SS# _____

How is patient related? Self Spouse Child (circle one)

I authorize my Insurance company to pay Brookside Optometric Group for the above services. I understand that I am responsible for any charges denied by my insurance company and that Brookside Optometric Group assumes no liability for the accuracy of the benefits information that has been provided for them. **If there is no insurance company to bill**, I understand that I am liable for all charges incurred during this and subsequent visits. I also understand that payment is due at the time of service unless prior arrangements have been made and that custom orders will not be processed until one half of the balance is paid. I have also been given the opportunity to read the privacy policy that Brookside Optometric Group has in place to guard my protected health information for compliance with the Health Insurance Portability and Accountability Act.

X _____

Date _____

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Health Form

Patient Name _____

Have you or your relatives been diagnosed with any of the following?

	Your You	Your Family		Your You	Your Family	
<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>		Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>		Turned or Crossed eye	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Stroke
<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders
<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Thyroid Disease

Who is your Medical Doctor? _____

Please list all medications you are currently taking:
(include vitamins and over the counter meds; check here if none)

Are you allergic to any medications? _____

Are you a smoker? **Yes** **No** Use Alcohol? **Yes** **No** Illegal Drug Use? **Yes** **No**

Please describe any eye injuries or surgeries you have had. _____

When was your last eye examination? _____

Do you wear contact lenses? **Yes** **No** Would you be interested? **Yes** **No**

If you do wear contact lenses, are you having any problems? _____

Do you experience seasonal(hay fever) allergies? _____

What is the main purpose of your visit today? _____

office use