Welcome! In order to meet all of your eye care needs, please take the time to fill out the front and back of this form. If you need assistance please ask. Thank you!

Patient name________________________________ Date of birth______________________ Age_____

Address_______________________________________ City_______________________ State______ Zip___________

Phone #______________________________ home / cell

E-mail___________________________________ Male___ Female___ Circle one: Married Divorced Single Widowed

Last 4 of SSN_________ Drivers License #_____________________________ State______________________

Vision Insurance Provider_________________________ Ins ID#/Policy#/Group# ___________________________

Major Medical Provider _________________________ Ins ID#/Policy#/Group# ___________________________

Occupation________________________ Employer_________________________________

Employer phone_______________

Circle one: Spouse or Parent

Name________________________________ Date of birth______________________ Age_____

Phone no______________________________ home / cell E-mail_________________________________

Last 4 of SSN___________ Drivers License #_____________________________ State_____

Vision Insurance Provider_________________________ Ins ID#/Policy#/Group# ___________________________

Major Medical Provider _________________________ Ins ID#/Policy#/Group# ___________________________

Occupation_________________________________ Employer_________________________________

Employer phone______________________

Emergency Contact person______________________________________ **Phone**________________________

If Minor: Name of School or College____________________________________ grade_________________

By signing below, you signify that you agree that in the course of providing service to you, we create, receive, send and store health information that identifies you. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services, refer you to another specialist and to conduct health care operations involving our office.

I certify that the above information is true and correct. I authorize Dr. Ibanez and/or Dr. Bonander to act as my agent in helping me obtain payment of my insurance benefits, and I authorize payment of these benefits directly to the doctor on my behalf for any services and materials furnished. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown and authorizes my doctor to act as my agent as above. I understand that any quote from the insurance company is only an estimate and not an actual guarantee of payment. I understand that I am responsible for the balance of fees due.

____ ___________________________

Patient/Parent Signature Today's Date

Circle "yes" or "no" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems

	Yourself		Family member		Who:		Yourself		Family member		Who:
AIDS/HIV	Yes	No	Yes	No		**Hepatitis**	Yes	No	Yes	No	
Arthritis	Yes	No	Yes	No		**High Blood Pressure**	Yes	No	Yes	No	
Artificial Heart Valve	Yes	No	Yes	No		**Kidney Disease**	Yes	No	Yes	No	
Artificial Joints	Yes	No	Yes	No		**Lazy Eye**	Yes	No	Yes	No	
Asthma	Yes	No	Yes	No		**Lupus**	Yes	No	Yes	No	
Bleeding	Yes	No	Yes	No		**Migraine Headaches**	Yes	No	Yes	No	
Cancer	Yes	No	Yes	No		**Pacemaker**	Yes	No	Yes	No	
Cataracts	Yes	No	Yes	No		**Psychiatric**	Yes	No	Yes	No	
Chemical Dependency	Yes	No	Yes	No		**Poor Color Vision**	Yes	No	Yes	No	
Diabetes	Yes	No	Yes	No		**Retinal Disease**	Yes	No	Yes	No	
Drug Sensitivity	Yes	No	Yes	No		**Shingles**	Yes	No	Yes	No	
Emphysema	Yes	No	Yes	No		**Skin Conditions**	Yes	No	Yes	No	
Epilepsy	Yes	No	Yes	No		**Stroke**	Yes	No	Yes	No	
Eye Surgery	Yes	No	Yes	No		**Thyroid Conditions**	Yes	No	Yes	No	
Flashes	Yes	No	Yes	No		**Tuberculosis**	Yes	No	Yes	No	
Floaters or Spots	Yes	No	Yes	No		**Turned Eye**	Yes	No	Yes	No	
Glaucoma	Yes	No	Yes	No		**Ulcers**	Yes	No	Yes	No	
Hay Fever	Yes	No	Yes	No		**Vascular Disease**	Yes	No	Yes	No	
Heart Condition	Yes	No	Yes	No		**Vision Loss**	Yes	No	Yes	No	
Itchy Eyes	Yes	No	Yes	No		**Weight Gain/loss**	Yes	No	Yes	No	
High Colesterol	Yes	No	Yes	No		**Alcohol Use**	Yes	No	Yes	No	
Females: Nursing?	Yes	No	Yes	No		**Tobacco Use**	Yes	No	Yes	No	

Medications

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Allergies

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Pharmacy name:______________________________

Physician's name: _________________________
Date of last visit:_________________________
Last Eye Doctor:__________________________
Date of last eye exam:______________________

Do you wear glasses? Yes No Contacts? Yes no
All the time Occasionally Reading Driving TV
Contacts Brand___________________ Hours/Day____
Any problems with glasses/contacts?_______________

______________________________________ ______________________________________
Patient/Parent Signature Date Doctor Signature Date

______________________________________ ______________________________________
Patient/Parent Signature Date Doctor Signature Date

______________________________________ ______________________________________
Patient/Parent Signature Date Doctor Signature Date