GRANGE VISION

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Please fill out front and back of form. Date: _____

PATIENT

Last Name _____ First Name _____ Initial _____

Social Security # _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Sex: ☐ M ☐ F Birth Date _____

Ethnicity: ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic ☐ White ☐ Other _____

eMail Address _____

Preferred method of communication: ☐ Mail ☐ Phone ☐ eMail

Primary Physician _____

Street Address _____ State _____ Zip _____

Employer _____ Occupation _____

☐ F/T ☐ P/T ☐ Retired ☐ Student-School _____

How did you learn about our practice? _____

INSURANCE INFORMATION

SS# _____

Vision Insurance _____ Policy # _____

Medical Insurance _____ Policy # _____

RESPONSIBLE PARTY (Who carries the insurance) _____

Relationship to Patient _____

Address (if different than above) _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Birth Date _____ SS# _____
Used for insurance purposes

Work Phone _____

Payment is requested when services are rendered.

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the doctor named above, and I am financially responsible for non-covered charges. I also authorize the release of any information necessary to process this claim.

SIGNATURE _____ DATE _____

We appreciate the opportunity to serve you!

PATIENT HEALTH HISTORY

Name _____ Date _____

	Yes	No
Do you currently wear glasses?	☐	☐
Do you currently wear contacts?	☐	☐
Have you had Laser Vision Correction?	☐	☐
Are you interested in Laser Vision Correction?	☐	☐

Approximately how many hours a day do you work on a computer? _____

List any special interests, hobbies or job requirements that may be affecting your vision.

_____ _____ _____

_____ _____ _____

Are you pregnant or nursing? (Female only) ☐ Yes ☐ No

Are you experiencing any of the following? (Please check any that apply.)

Burning Eyes	☐	Eye Strain	☐	Lazy Eye	☐	Red Eyes	☐
Distance Vision Blurred	☐	Eye Surgery	☐	Light Sensitivity	☐	See Spots	☐
Double Vision	☐	Flashing Lights	☐	Loss of Vision	☐	Twitching Eyelids	☐
Dry Eyes	☐	Headaches	☐	Near Vision Blurred	☐	Watering Eyes	☐
Eye Injury	☐	Itching Eyes	☐	Migraine Headaches	☐		

Please check which of the following apply to you or a family member.

	Self	Family		Self	Family
Blindness	☐	☐	Cancer	☐	☐
Cataracts	☐	☐	Diabetes	☐	☐
Glaucoma	☐	☐	Hay Fever	☐	☐
Macular Degeneration	☐	☐	Heart Condition	☐	☐
Retinal Detachment	☐	☐	High Blood Pressure	☐	☐
			High Cholesterol	☐	☐
AIDS	☐	☐	Migraine Headaches	☐	☐
Allergies	☐	☐	Rheumatoid Arthritis	☐	☐
Anemia	☐	☐	Skin Conditions	☐	☐
Asthma	☐	☐	Thyroid Disease	☐	☐
			Smoker ☐ Yes ☐ No		

Please list any medication(s) that you take.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any medication(s) to which you are allergic.

_____ _____ _____

_____ _____ _____