Name:_____ M F Today's Date ___/___/_____

Address:_____ Phone:_____

City:_____ Zip:_____ Work Phone:_____

Date of Birth:___/___/_____ Social Security #: _____/___/_____ Occupation:_____

Communication Preference: Phone E-Mail Mail Email: _____

Name of Medical Doctor: _____ Dr.'s Phone:_____

Primary Insured: _____ Relationship to Patient: _____

MEDICAL HISTORY

Do you have any allergies to medications? Yes No If yes, list and explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major conditions, injuries, surgeries, and/or hospitalizations you have had:_____

_____

_____

OCULAR HISTORY

Glasses: No Yes If yes, how old is your current pair? _____

Contacts: No Yes If yes, what kind and how old is your current pair? _____

List any eye drops you currently use: _____

List any ocular surgeries you have had: _____

Please circle any condition you currently have: Last Eye Exam: ___/___/_____

Crossed eyes	Blurred vision	Double vision	Dry eyes	Watery eyes
Red eyes	Flashes/ floaters	Cataracts	Glaucoma	Retinal Disease

FAMILY HISTORY

Please circle any family history (living or deceased) for any systemic/ocular conditions & their relationship to you:

Glaucoma Macular Degeneration Diabetes Hypertension Other: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I reviewed/received a copy of the Notice of Privacy Practices for this office.

_____ _____

Patient/Guardian Signature Date

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits for any services provided to me, be made on my behalf to Drs. Heiden & Heiden, PA. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.
I understand that I am responsible for charges not paid by my insurance plan within 90 days.
Fees for professional services are due at the time services are rendered. A deposit is required at the time materials are ordered.

_____ _____

Patient/Guardian Signature Date