**PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_  
(If patient is a child, Name of Parent)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL SECURITY # OF PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL/BUS PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE PRIMARY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SECONDARY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
ID # OF POLICY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF PRIMARY INSURED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_  
SS# OF INSURED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OCC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GENERAL HEALTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ CURRENT MEDICATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HISTORY (i.e., glaucoma, diabetes, heart disease):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU WEAR GLASSES? \_\_\_\_\_ \_\_\_\_\_\_\_\_ CONTACT LENS’? \_\_\_\_\_\_\_\_\_  
 POWER:\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  
 BC\_\_\_\_\_\_\_\_\_ DIA\_\_\_\_\_\_\_\_\_\_\_  
 BRAND:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHARMACY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHARMACY PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-MAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, HEREBY AUTHORIZE THE OFFICE TO SUBMIT MY CLAIMS ON MY BEHALF TO MY INSURANCE COMPANY  
SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREFERRED LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**QUESTIONAIRE- PLEASE CIRCLE ONE OF THE FOLLOWING**

**ETHNICITY:**

**HISPANIC NON-HISPANIC NOT SPECIFIED**

**TOBACCO USE (please check off which applies to you)**

**\_\_\_\_0 CIGARETTES PER DAY (less than 100 in life time, non-smoker)**

**\_\_\_\_0 CIGARETTES PER DAY (previous smoker)**

**\_\_\_\_1-3 CIGARETTES PER DAY**

**\_\_\_\_UP TO 1 PACK PER DAY**

**\_\_\_\_1-2 PACKS PER DAY**

**\_\_\_\_2 OR MORE PACKS PER DAY**