Welcome To Our Office

Patient Name_____ Date of Birth_____
If Child, Parent's Name_____
Address_____
City_____ State_____ Zip_____
Phone: Home (____) _____ Work (____) _____ Cell (____)_____
E-mail_____

Occupation_____
List work/hobbies that may require special vision care_____

Last Eye Exam_____ By Whom_____
Do you wear glasses?_____ If yes, how old are they? _____
Do you wear contact lenses?_____ If yes, how old are they? _____
How were you referred to our office? _____

MEDICAL HISTORY
Medical Dr. _____ Last Visit _____

Do you have any of the following conditions (past or present)?

	Yes	No		Yes	No		Yes	No
Diabetes	____	____	Cataracts	____	____	Discharge	____	____
High Blood Pressure	____	____	Glaucoma	____	____	Light Flashes	____	____
Lung Disease	____	____	Eye Injury	____	____	Floaters	____	____
Heart Disease	____	____	Eye Surgery	____	____	Double Vision	____	____
Cancer	____	____	Lazy Eye	____	____	Blackouts	____	____

Do You Smoke? ____ ____
List any other medical and/or ocular conditions not listed above: _____
_____

List any Allergic reactions to medications or other substances: _____
_____

List Medications:
_____
_____

FAMILY HISTORY: Do any family members have?
Glaucoma: Yes No Retinal Disease: Yes No Macular Degenration: Yes No

INSURANCE ASSIGNMENT: I authorize Medicare or Other Insurance payments be made to: Doctor Butler Eyecare, for any services furnished to me by that doctor. I authorize medical information to be released to determine benefits payable for related services. I am responsible for any charges denied by my insurance.

Patient/Parent Signature_____ Date _____