

Date \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last Name First Name MI

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex    M    F      Marital Status    Single    Married    Widowed    Separated    Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Reason for visit \_\_\_\_\_

Last Exam Date \_\_\_\_\_

**CONDITIONS** Check conditions you have or have had in the past

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seeing Halos
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sensitivity to Light
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Wear Contact Lenses
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Floaters	<input type="checkbox"/> Retinal Disease	Type of Lenses _____
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Seeing Flashes	Hours per Day _____

Family History		Allergies
Disease	Relationship to you	List any allergies to medication or substances
<input type="checkbox"/> Blindness		
<input type="checkbox"/> Cataracts		<b>Medications: List medications you are currently taking</b>
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Glaucoma		

**Insurance Information**

Person responsible for account \_\_\_\_\_ Relation to patient \_\_\_\_\_  
Last Name First Name MI

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Phone \_\_\_\_\_ Employer \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Payment is expected at the time services are rendered, including non-covered portions of insurance.*

*Note: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance company or human resource department. We cannot guarantee the accuracy of benefit information given to us by your insurance company.*

**Please understand that financial responsibility for your account is yours, not your insurance company's.**

- I authorize the release of any medical or other information necessary to process insurance claims.
- I authorize payment of medical benefits to Darren F. Osterloh O.D.
- HIPAA Compliance: I hereby acknowledge that I have seen a posted copy of Darren F. Osterloh O.D.'s Notice of Privacy Practices.

I have read and understand the above statements.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_