Patient Information

Thank you for choosing us as your eye care provider. Please help us better meet your needs by updating the information below

Today's Date:

First name: Middle: Last Name:
Nick Name: Patient Sex:
Address: City: State: Zip:
Cell Phone: Home Phone: Work Phone:
Email:
SSN: DOB: Age:
Employer: Occupation:
Employment Status: Full-Time Part-Time Student Full-Time Student Part-Time
Marital Status:

***INFORMATION REQUIRED* to bill insurance company, and to meet government guidelines:**
Government Guidelines:
Height:_____ Weight:_____
Race:_____ Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
Preferred Contact Type: Email Phone Mail
Language Preferred_____

Vision-related sports, hobbies, or special visual needs_____
_____

Purpose of Todays Visit

__Distance Blur__Near Blur __Redness __Itching __Burning __Pain __Light Sensitivity
__Need New Glasses __Glaucoma Testing __Cataract Check __Interested in Contacts
__Laser Surgery Evaluation __Other_____

Please circle **"S" for self, and "F" for family (or both)** for present or past conditions below.
Circle specific choices for listed items if applicable (ex. Floaters but no Flashes)

S F Double Vision
S F Sudden Loss of Vision
S F Retinal Deseases
S F Eye Turn "Lazy Eye"
S F Diabetes
S F Intestinal Digestive Disorders
S F Kidney Liver Diorders
S F High Blood Pressure
S F Hearing Problems
S F Auto Immune Diseases
S F Asthma Bronchitis Lung Problems
S F Flashes Floaters Spots
S F Glaucoma
S F Eye Injury Head Injury
S F Dry Eye
S F Thyroid Conditions
S F Cancer Tumor
S F Fainting Dizziness
S F HIV AIDS
S F Vision Training/Therapy
S F Concentration/Memory Problems
S F Color Blindness
S F Heart Conditions
S F Blindness
S F Eye Surgery
S F Headaches
S F Skin Conditions
S F Arthritis
__**NO Known Conditions**

Women: Are you Pregnant? Yes No Nursing? Yes No

Alergies Full List:

Do you currently use: Alcohol Yes No Tobacco: Yes No Other Substances: Yes No
Please list any current medications (including birth control, vitamins, any over the counter drugs, etc.): _____

_____

_____

_____

Primary Doctor
Phone Number:
Date of last complete eye exam (including glaucoma testing):
Date of last physical:

For Contact Wearers Only

Are you wearing contact lenses today? Yes No Brand_____
Age of current pair_____ Solution Used_____
Average # of hours worn daily_____hours X_____days of week
Do you sleep in your contacts? Yes No **IF YES** how many times per week?_____
How often do you replace your lenses with a fresh pair?_____
On a scale of 1 to 10 **(10 being the BEST)** how comfortable are your lenses?_____

Insurance Information

Insurance 1 Name:
Ins ID: Ins 1 Policy Group:
Ins 1 Address: City: State: Zip:
Ins 1 Phone:
Ins 1 Primary Name:
Ins 1 Birthday: Sex:
Ins 1 SSN:

Insurance 2 Name:
Ins 2 ID: Ins 2 Policy Group:
Ins 2 Address: City: State: Zip:
Ins 2 Phone:
Ins 2 Primary Name:
Ins 2 Birthday: Sex:
Ins 2 SSN:

It is the patient's responsibility to know their individual benefit coverage.

PLEASE READ AND SIGN THE FOLLOWING CONSENT REQUESTS. If you do not wish to give permission to any of the following requests please indicate that *YOU DO NOT GIVE PERMISSION*:

I have read and understand the following: Payment is due at time for services rendered. Full payment is due before products will be released. A restocking fee of 10% will be charged for products not picked up within 60 days unless otherwise arranged. I accept responsibility for payment of all charges whether covered by insurance or not. There are no refunds on professional fees.

Signature_____ Date_____
Responsible Party

I give permission for this office to exchange my medical information with other health care providers if a referral is needed.

Signature_____ Date_____
Responsible Party

I give permission for Eye Logic and/or Dr. Amy Gallegos and Associates to contact me via electronic communication routes for appointment reminders, marketing, or any other instances that may be related to my health.

Signature_____ Date_____
Responsible Party

I give permission for the person(s) listed below to pick-up my ophthalmic products.

Please list Name(s) and DOB(s):

Signature_____ Date_____
Responsible Party

WE WILL NOT SHARE YOUR E-MAIL ADDRESS WITH OTHER COMPANY OR BUSINESS