SPECIAL EYES

Patient Information and Health History Form

Date_____

Patient's Name _____ Birthdate_____Age _____

Parent's Name (if minor)_____ Social Security #_____

Address _____ Home Tel.# _____

City_____ Work Tel.# _____

State_____ Zip Code _____ Cellular Tel.# _____

Occupation_____

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Vision Insurance Information

Vision Insurance Plan _____Insured's Name_____

Insured's SS #_____Insured's DOB _____

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Medical Insurance Information

Insurance Company Name_____Group #_____Telephone #_____
Please circle one: PPO/HMO/POS
Insured's Name___ _____Insured's SS #_____Insured's DOB___ _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Special Eyes to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Responsible Party _____Date_____

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Reason for seeking vision care at this time _____
Please list any eye infection, injury or surgery _____
Please list any medications that you are allergic to_____
Please list any medications that you are taking_____
_____

(Please circle any that apply below.)

Personal Ocular History

Redness	Dryness
Burning	Squinting
Floaters	Double Vision
Headaches	Flashes of Light
Watering	Blurred Vision
Tired	Lazy Eye
Glaucoma	Eye Turn
Cataracts	Blindness

Personal Medical History

High Blood Pressure	Blackouts
Diabetes	Dizzy Spells
Seasonal Allergies	Sinus Trouble
Head Injury	Asthma
Cancer	Arthritis
Epilepsy	Skin Disorders
Pregnant/Nursing	Thyroid Disease
Heart Condition	Other_____

Family History

Glaucoma Blindness Retina Detachment
Cataracts Macular Degeneration
Diabetes High Blood Pressure Cancer

Contact Lenses

Soft Disposable Toric Colored
Overnight Wear Rigid Gas Permeable
Current Brand of Solution_____
Any problems with your contacts?_____
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