

Northwest Ohio Eyecare

Welcome to Our Office

To Help Us With Your Visual and Ocular Health Care, Please Fill Out the Following Form

****Please make sure we have a copy of your current medical & vision insurance cards****

Last Name _____ First _____ MI _____ Date of Birth _____
Street Address _____ Mailing Address _____
City _____ State _____ Zip _____ Marital Status: S M W D Sex: M F
Home Phone _____ Cell Phone _____ Work Phone: _____
E-mail _____ Social Security Number _____ - _____ - _____
Employer: _____ Occupation: _____
Insured's Name: _____ Insured's Date of Birth _____
Insured's SSN _____ - _____ - _____ Insured's Address: _____
Insured's Employer _____ Vision Insurance: _____
Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Health Questionnaire

Please circle all that apply. **Y= Yes N= No**

	Self	Family		Self	Family		Self	Family
Hypertension	Y N	Y N	Diabetes	Y N	Y N	High Cholesterol	Y N	Y N
Heart Disease	Y N	Y N	Arthritis	Y N	Y N	Respiratory	Y N	Y N
Thyroid	Y N	Y N	Headaches	Y N	Y N	Musculoskeletal	Y N	Y N
Allergies	Y N	Y N	Cancer	Y N	Y N	Gastrointestinal	Y N	Y N
Genitourinary	Y N	Y N	Mental	Y N	Y N	Skin Disorders	Y N	Y N

Please list all your medications: _____

(Including Over the Counter) _____

Any known allergies to medications? Y N _____ Medical Doctor: _____

Do you use cigarettes/ tobacco? Y N Do you drink alcohol? Y N

Ocular Health History

	Self	Family		Self	Family
Glaucoma	Y N	Y N	Cataracts	Y N	Y N
Lazy Eye	Y N	Y N	Eye Surgery/ Injury	Y N	Y N
Blindness	Y N	Y N	Macular Degeneration	Y N	Y N
Flashes/ Floaters	Y N	Y N	Dry Eyes	Y N	Y N

I authorize the release of my medical information to process my third party claim. I understand that if I do not provide my insurance cards I will be responsible for any fees incurred.

X _____ **Date** _____