WELCOME TO OUR OFFICE

PATIENT INFORMATION

Date_____/_____/_____

□ Mr. □ Mrs. □ Ms. □ Miss □ Dr.

Patient Name_____
(LAST) (FIRST) (M.I.)

D.O.B._____/_____/_____ Age_____

□ Married □ Single □ Widow □ Other

□ Male □ Female

Address _____

City_____ State _____ Zip Code _____

Home Phone( )_____-_____Cell( )_____-_____

E-mail Address _____

Occupation _____Work( )_____-_____

Employer _____

In compliance with HIPAA regulations all information will be kept confidential. Please read and sign below:

I,_____, acknowledge the Privacy Policy of Sunburst Optical (the "provider"), and have been offered a copy of such policy for my records.

Signature_____ Date _____
(PATIENT OR RESPONSIBLE PARTY)

INSURANCE INFORMATION

Is patient covered by Vision Insurance? □ Yes □ No

If so which Vision Insurance?_____

Member's Name _____
(LAST) (FIRST) (M.I.)

Member's ID#_____ D.O.B._____/_____/_____

Is patient covered by Medical Insurance? □ Yes □ No

If so which Insurance?_____

Member's Name_____
(LAST) (FIRST) (M.I.)

Member's ID#_____ Group#_____

Member's Date of Birth_____/_____/_____

I authorize payments of benefits to Sunburst Optical. I agree to be financially responsible for any balance not paid by my insurance plan.

Signature_____ Date _____
(PATIENT OR RESPONSIBLE PARTY)

Whom may we thank for referring you to our Office?

□ Walk-In □ Insurance Website □ Previous Patient

□ Family/Friend □ Other _____

***Primary reason for today's visit:**_____

EYE HEALTH HISTORY

Date of last Eye Exam_____/_____/_____ Do you currently wear glasses? □ Yes □ No Are you happy with them? □Yes □ No

Do you wear Contacts? □ Yes □ No If so, what kind? _____ Are they comfortable? □ Yes □ No

Are considering refractive surgery/LASIK? □ Yes □ No When? _____

Disease/Condition	Yes	No	Family	Disease/Condition	Yes	No	Family
Blindness/Loss of Vision	□	□	□	Eye Pain or Soreness	□	□	□
Blurred Vision – Distance	□	□	□	Floaters/Flashes of Light	□	□	□
Blurred Vision – Near	□	□	□	Glare/Light Sensitivity	□	□	□
Cataracts	□	□	□	Glaucoma	□	□	□
Chronic infection of eye or lid	□	□	□	Itchy/Watery eyes	□	□	□
Crossed Eyes	□	□	□	Lazy Eye	□	□	□
Distorted Vision/Halos	□	□	□	Macular Degeneration	□	□	□
Double Vision	□	□	□	Retinal Detachment	□	□	□
Eye Injuries	□	□	□	Styes or Chalazion	□	□	□

If answered yes to Eye Injuries or Eye Surgeries please explain: _____

_____

-Wait, there's more on the back!-

SOCIAL HISTORY

This information is kept strictly confidential. However you may discuss this portion directly with the Doctor if you prefer.

I would prefer to discuss my social history directly with the doctor: □ Yes □ No

Do you drive? □ Yes □ No If yes do you have any visual difficulty while driving? □ Yes □ No If yes please describe:

_____

Do you use tobacco products? □ Yes □ No If yes, type/amount/how long:_____

Do you drink alcohol? □ Yes □ No If yes, type/amount/how long:_____

Do you use illegal drugs? □ Yes □ No If yes, type/amount/how long:_____

REVIEW OF SYSTEMS

Do you currently or have you ever had any problems in the following areas:

SYSTEM	YES	NO	FAMILY	SYSTEM	YES	NO	FAMILY
CONSTITUTIONAL				EARS/NOSE/MOUTH/THROAT			
Fever, Weight Loss/Gain	□	□	□	Allergies/Hay Fever	□	□	□
INTEGUMENTARY (SKIN)	□	□	□	Sinus Congestion	□	□	□
NEUROLOGICAL				Runny Nose	□	□	□
Headaches	□	□	□	Post Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat/Mouth	□	□	□
ENDOCRINE				RESPIRATORY			
Thyroid/Other Gland	□	□	□	Asthma	□	□	□
ALLERGIC/IMMUNOLOGIC	□	□	□	Chronic Bronchitis	□	□	□
PSYCHIATRIC	□	□	□	Emphysema	□	□	□
GASTROINTESTINAL				VASCULAR/CARDIOVASCULAR			
Diarrhea	□	□	□	Diabetes	□	□	□
Constipation	□	□	□	Heart Pain	□	□	□
GENITOURINARY				High Blood Pressure	□	□	□
Genitals/Kidney/Bladder	□	□	□	Vascular Disease	□	□	□
BONES/JOINTS/MUSCLES				LYMPHATIC/HEMATOLOGIC			
Rheumatoid Arthritis	□	□	□	Anemia	□	□	□
Muscle Pain	□	□	□	Bleeding Problems	□	□	□
Joint Pain	□	□	□				

If you answered YES to any of the above or have a condition not listed please explain: _____

_____

Do you have any allergies to medication? □ Yes □ No If yes, explain:_____

Are you currently taking medication? (Include Vitamins & OTC products):_____

Any major injuries, surgeries or hospitalizations? □ Yes □ No If yes, explain:_____

Thank You for your continued business and support!

Doctor's signature (History reviewed with patient):_____Date_____ /_____ /_____