Please Fill out Completely PLEASE PRINT

Date _____

* PATIENT'S NAME: (Mr. Mrs. Ms. Dr.) _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone # ( ) _____ Work Phone # ( ) _____

Age _____ Birthdate _____ Social Security # _____

Sex: M F Marital Status: S M W D Name of Spouse _____

* Patient Employer's Name _____ Occupation _____

Employer's Address _____

* Is this a Worker's Compensation Claim? Yes No

Contact Name _____ Contact Phone # ( ) _____

* **In case of an Emergency, who can we contact?** Name _____
(SOMEONE WHO IS NOT AT THE SAME ADDRESS)

Phone # ( ) _____

* Person responsible for payment?

Name _____ Relationship _____

Address _____ Social Security # _____

Home Phone # ( ) _____ Work Phone # ( ) _____

* Primary Care Physician _____ Phone # ( ) _____

Address _____

* Were you referred to our office by a PHYSICIAN? If so:

Dr. Name _____ Phone # ( ) _____

Address _____

Next page please.....

* If the Insurance policy is through your spouse or parent, fill out the following information:

Primary Insurance Information:

Insurance Company _____ Name of Insured _____
Insured Date of Birth _____ Relationship to Patient _____

Secondary Insurance Information:

Insurance Company _____ Name of Insured _____
Insured Date of Birth _____ Relationship to Patient _____

If your insurance contract requires you to have a referral, verbal referral or authorization number, it is your responsibility, before the office visit, to have the necessary referral and paperwork. If no referral is present, you will be responsible for the office visit and any supplies at the time of the visit.

BRIEF MEDICAL HISTORY

* Do you have or have you had: (circle Yes or No)

Allergies	Y	N	Heart Disease	Y	N
Asthma/Emphysema	Y	N	High Blood Pressure	Y	N
Autoimmune Disease	Y	N	Liver Disease	Y	N
Blood Disorders	Y	N	Neurological Disorder (Parkinsons, Stroke, MS)	Y	N
Cancer	Y	N	Skin Disease	Y	N
Diabetes	Y	N	Stomach or Intestinal Disease	Y	N

Other Serious Illness _____

Major Surgery _____ Date of Surgery _____
(within the past 5 years)

Do you smoke? Y N Do you use Alcohol? Y N
How much? _____ How much? _____

Please list medications you are currently taking including non-prescription and dietary supplements:

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

By signing below, I am stating that I understand this policy. Also, by signing below I am authorizing Northwest Eye Physicians, Ltd. to furnish to my insurance company all the necessary information which they may request. I certify the above information is true and correct, and I will notify you of any changes in my health status or any other information I have provided.

_____ _____

Patient's Signature and Date Insured/Guardian's Signature and Date