Patient's Full Legal Name ____

Last First MI

Name you prefer we use ____________ Sex M F Date of Birth ____________ Martial Status ____________

Social Security #: ____________ Name of Parents (if minor) ____________

Home Address: ____________ City ____________ State ______ Zip ______

Home Phone ____________ Business Phone ____________ Cell ____________

Email: ____________ Who referred you to us? ____________

Employer ____________ Occupation ____________

Spouse ____________ SSN ____________ Date of Birth ____________

Emergency Contact ____________ Relationship ____________ Phone ____________

Insurance Information

Health Plan ____________ Vision Plan ____________ Policy # ____________

Name of Insured ____________ SSN ____________ Date of Birth ____________

Patient Eye Health (check all that apply)

☐ Amblyopia (Lazy Eye)	☐ Blurred Vision – Far	☐ Blurred Vision – Near
☐ Burning Eyes	☐ Cataracts	☐ Double / Distorted Vision
☐ Drooping Eyelid	☐ Dry Eyes	☐ Eye Surgeries
☐ Eye Turn	☐ Floaters / Spots	☐ Fluctuating Vision
☐ Foreign Body Sensation	☐ Glaucoma	☐ Glare / Light Sensitivity
☐ Headaches	☐ Itchy Feeling	☐ Infection of Eye / Lid
☐ Loss of Vision – Central	☐ Loss of Vision – Side	☐ Mucus / Discharge
☐ Redness	☐ Retinal Detachment	☐ Tearing / Watery Eyes

Reason for Current Visit ____

Date of Last Exam ____________ By Dr. ____________

Do you have trouble driving at night? Y N

Do you wear contacts? Y N Brand ____________

Do you wear glasses? Y N

Are you interested in LASER vision correction? Y N

Do you have trouble seeing the computer? Y N

Do you have any special visional needs? ____________

Patient General Health (check all that apply)

☐ Allergies ☐ Asthma / Respiratory ☐ Blood Disorders
☐ Cancer ☐ Cardiovascular / High B.P. ☐ Chronic Bronchitis
☐ Chronic Cough ☐ Diabetes ☐ Emphysema
☐ Gastrointestinal Problems ☐ Heart Attack / Stroke ☐ Headaches / Migraines
☐ Kidney Disorders ☐ Psychiatric / Depression ☐ Rheumatoid Arthritis
☐ Thyroid / Endocrine ☐ Tobacco / Alcohol Use ☐ Weight Loss / Gain

Family History – Blood Relatives (check all that apply)

☐ Amblyopia (Lazy Eye) ☐ Arthritis ☐ Blindness
☐ Cancer ☐ Cataract(s) ☐ Color Blindness
☐ Diabetes ☐ Eye Turn ☐ Glaucoma
☐ High Blood Pressure ☐ High Cholesterol ☐ Macular Degeneration
☐ Retinal Detachment ☐ Stroke / Heart Attack ☐ Thyroid Disease

Medications (including over the counter medications): ______________________________

____

For what condition?____

Have you had any surgeries? If so for what?______________________________

All fees are due and payable in full at the time of services and/or materials are provided. If you wish to make payments, we accept all major credit cards. Patients are personally responsible for all services and materials. If your insurance does not clearly show what services or materials you are eligible for, you will need to pay for those services and materials when they are provided.

I authorize Dr. McQuillan and his staff to act as my agent in helping me obtain payment from my insurance carriers. I authorize release of all information to my insurance carriers. I authorize payment directly to Dr. McQuillan.

I have read the above statements and hereby acknowledge understanding and agreement.

Authorized Signature: ______________________________ Date______________

Reviewed____________ Reviewed____________ Reviewed ____________ Reviewed____________ Reviewed________

11/09