Patient Information - Please Print

Patient's name:	DOB: Age:
Address:	Home Telephone:
City State ZIP:	Day/Work Telephone:
Primary Insurance:	Gender: F
Primary Insurance ID#	Occupation:
If patient is under age 18, Parent/Guardian Name:	
Patient Nickname:	Date of Last Exam:

ASSIGNMENT: I, the undersigned, certify that I, or my dependent, have insurance coverage with the company(s) listed above. I assign all insurance benefits directly to Sterling Vision of Wesley Chapel. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date

HOW DID YOU HEAR ABOUT US? _____

DILATION:

In order to assure the highest level of eye health examination, the doctors recommend either dilation of the eyes. exam Please indicate what you would prefer:

___ I prefer my eyes be dilated (no additional fee)

___ I prefer no dilation at this time – requires patient initials: ___

___ Contact exam OR ____ Eyeglass exam OR _____Both

HEALTH HISTORY Physician's (PCP) Name _____ Last Visit _____

Please indicate if you or a blood relative has had any of the following:

You	Relative		You	Relative	
☐	☐	Allergies	☐	☐	Heart Condition
☐	☐	Arthritis	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	High Cholesterol
☐	☐	Cataracts	☐	☐	Lazy Eye
☐	☐	Diabetes	☐	☐	Macular Degeneration
☐	☐	Drug Sensitivity	☐	☐	Migraine Headache
☐	☐	Eye Injury	☐	☐	Psychiatric Disorder
☐	☐	Eye Surgery	☐	☐	Retinal Disease
☐	☐	Glaucoma	☐	☐	Skin Conditions
☐	☐	Headache	☐	☐	Thyroid Conditions

Do you have any medical conditions not listed above: No Yes

Do you use tobacco: No Yes: ___/day Do you use alcohol: No Yes: occasionally daily

List any medications you currently use _____

List any allergies to medications: _____

Your reason for today's visit: _____

PRIVACY INFORMATION

We want our patients to know that we have a privacy policy in place for your protection. You have the right to review the Notice of Privacy Policy. It is posted on the clipboard. I acknowledge that I have read (or been given the opportunity to read) the Notice.

Signature: _____ Date: _____

I understand that due to electronic filing there are no cancellations, exchanges, refunds, or changes to my eyewear order, including lenses, frame, lens features or coatings.

Sign: X _____

Polycarbonate lenses have been explained and I decline polycarbonate.

Sign: X _____