Midland Eye Care

Drs. Johnson & Associates

A MEMBER OF VISION SOURCE

(In order to serve you efficiently and legally, we will need the following information)

Today's Date: ____/_____/_____

PATIENT INFORMATION:

Name: _____ Nickname: _____

Home Phone: ( )_____ Daytime Phone: ( )_____

Cell Phone: ( )_____ Patient's Pharmacy: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____/_____/_____ Date of Birth: _____/_____/_____

Sex: M F Marital Status: S M D W Age: _____

Family Physician: _____ Referred By: _____

Contact person in case of an emergency: _____ Phone: ( )_____

Patient's/Parent's Employer: _____ Occupation: _____

Patient's Spouse: _____ Work Phone: ( )_____

Spouses Employer: _____ Cell Phone: ( )_____

E-mail Address: _____ Call me at: Work/Home/Cell

Ok to leave messages: Yes No

RESPONSIBLE PARTY: (Person responsible for paying this account)

Name: _____ Home Phone: ( )_____

Address: _____ Work Phone: ( )_____

Relationship to patient: _____

MAJOR MEDICAL INSURANCE: Yes No I.E. Blue Cross, Medicare

(Copy of Insurance Card Needed)

Company: _____ Policy #: _____

Group #: _____ Policy Holder: _____ Birth Date: _____/_____/_____

VISION INSURANCE: Yes No (Copy of Insurance Card Needed)

Please Circle: Blue Cross VSP Medicaid EyeMed

Employer: _____ Policy #: _____

Group #: _____ Policy Holder: _____

Birth Date of Policy Holder: _____/_____/_____

OPTICAL INFORMATION:

Do you presently wear---------- Glasses Contacts Both None

Is your vision blurred with your glasses/contacts at a distance?	Yes	No
Is your vision blurred with your glasses/contacts while reading?	Yes	No
Would you be interested in trying Contact Lenses?	Yes	No
Would you be interested in Laser corrective surgery?	Yes	No

-PLEASE TURN OVER-

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MEDICAL HISTORY:

Allergies	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Cancer	Yes	No
Skin Disorder	Yes	No	Diabetes	Yes	No
Eye Diseases	Yes	No	Heart Disease	Yes	No
Eye Injury	Yes	No	High Blood Pressure	Yes	No
Lazy Eye	Yes	No	Kidney Disease	Yes	No
Cataracts	Yes	No	Anxiety Disorder	Yes	No
Glaucoma	Yes	No	Migraines	Yes	No
Eye Surgery	Yes	No	Other: _____		

MEDICATIONS: (List all medications you take, including: oral contraceptives, aspirin, over the counter medications and drops.)

_____

_____

ALLERGIES: (List all medications that have caused an allergic reaction.)

_____

_____

FAMILY MEDICAL HISTORY: (Circle and/or list any medical problems in your immediate family---Parents/Grandparents/Siblings)
Diabetes / High Blood Pressure / Heart Disease / Stroke / Arthritis / Lung Problems / Cancer / Thyroid Disease / Blindness / Lazy Eye / Cataracts / Glaucoma / Macular Degeneration / MS / Other:_____

SOCIAL HISTORY:

Do you drive? Yes No

Do you have difficulty driving with your glasses on? Yes No

Do you use tobacco products? Never Former Current

How much? _____packs/day How long? _____ yrs

Do you drink alcohol? Rare/Social Yes No How much? _____/day

1. I authorize the release of any medical information necessary to process insurance claims.
2. I authorize the release of payment for medical benefits to my physician.

- **Some tests and procedures may not be covered by your particular insurance carrier and will therefore be the responsibility of the patient.**
- **Patients may be seen out of order. We appreciate your understanding.**

Patient's/ Parent's Signature: _____ Date: _____

- ALL insurance co-pays must be paid at the time of service/orders.
- ALL OFFICE APPOINTMENTS WILL BE ON A CASH/CHECK BASIS. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER FOR YOUR CONVENIENCE. ANY OTHER FINANCIAL ARRANGMENTS MUST BE MADE BEFORE YOU SEE THE DOCTOR.