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: _____
Communication Preference: (circle one) CALL or TEXT
Primary Phone: ( )_____ Secondary Phone: ( )_____
E-mail Address: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____/_____/_____ Date of Birth: _____/_____/_____
Sex: M F Marital Status: S M D W Age: _____
Yearly Eye Exam Reminder Preference: (circle one) TEXT or POSTCARD
Patient's Pharmacy: _____
Family Physician: _____ Referred By: _____
Contact person in case of an emergency: _____ Phone: ( )_____
Patient's/Parent's Employer: _____ Occupation: _____
Patient's Spouse: _____
Spouses Employer: _____

RESPONSIBLE PARTY: (If not yourself)
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: VSP Medicaid EyeMed Spectera Superior Vision VBA

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-

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.

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