# PATIENT INFORMATION

DATE:_____ D.O.B.:_____ Patient ID # (Office Use):_____

LAST NAME:_____ FIRST NAME: _____ MI:_____

**EMAIL:**_____ **CELL PHONE:** _____

*Used for communication purposes only. **For minor patients, please provide the Parent/Guardian information.**

ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

**NEW PATIENT? Y N** LAST EYE EXAM (MONTH/YEAR)?_____ Occupation: _____

**HEY NEW PATIENT, HOW DID YOU HEAR ABOUT US?** Friend/Family:____ Social Media (ie. Yelp, Google):____

Insurance:____ Groupon:____ Walk-In:____ Other:_____

PART 1. HEALTH INSURANCE (Your health insurance may differ from your vision insurance)

**Do you have? MEDICARE or MEDICAID** (Circle One or Both, leave blank if neither)

**Other HEALTH INSURANCE:** _____**(Please provide Name)**

PART 2. VISION INSURANCE: Are you using vision insurance?

PLAN NAME:_____ ARE YOU THE PRIMARY? Y N **EMPLOYER** _____

NAME OF PRIMARY MEMBER: _____ YOUR RELATIONSHIP TO THE PRIMARY?_____

PRIMARY'S INSURANCE ID OR LAST 4 OF SSN?_____

*CIRLCE ANY OF THE FOLLOWING FORMS OF PAYMENT YOU WOULD LIKE TO USE TODAY:* ***FSA / HSA / CARE CREDIT***

## PART 3. PERSONAL/FAMILY HEALTH HISTORY (self and blood relatives):

| | YOU | FAM |
|---|---|---|
| Dry Eyes | | |
| Severe Headaches | | |
| Red Eyes | | |
| Cataracts | | |
| Head Injuries | | |
| Currently Pregnant | | |
| Currently Nursing | | |
| Seizures | | |

| | YOU | FAM |
|---|---|---|
| **Diabetes** | | |
| Eye Pain | | |
| Glaucoma | | |
| Hay Fever | | |
| Heart Condition | | |
| Floaters | | |
| Thyroid Disease | | |
| Eye Disease | | |

| | YOU | FAM |
|---|---|---|
| Inflammatory Disease | | |
| Light Flashes | | |
| Asthma/Allergies | | |
| Eye Surgeries | | |
| Dizziness | | |
| Blurry Vision Far | | |
| Blurry Vision Near | | |
| **High Blood Pressure** | | |

LIST ANY CURRENT MEDICAL TREATMENTS/CONDITIONS?_____ LAST PHYSICAL:_____

## WHAT BRINGS YOU IN TODAY?

Exam + Glasses:____ Contact Lens Exam:____ Previous CL Wearer:____ Lasik Referral:____ Sunglasses:____

Computer glasses:____ Red Eye:____ Dry Eyes:____ Eye Pain:____ DMV Referral:____ Other:_____

## DISCLAIMER:

BY SIGNING BELOW, PATIENT AUTHORIZES RELEASE OF INFORMATION TO THEIR INSURANCE COMPANY. PATIENT ALSO AUTHORIZES DR.NASR'S OFFICE TO ACT AS AN AGENT IN HELPING OBTAIN PAYMENT. **WE WILL REVIEW YOUR COVERAGE BASED UPON THE AUTHORIZATION WE WERE ABLE TO OBTAIN FROM YOUR INSURANCE. IF, HOWEVER INSURANCE DENIES COVERAGE FOR ANY SERVICES OR PRODCUTS, PATIENT IS RESPONSIBLE FOR THEIR OWN BILL.** PATIENT ALSO ACKNOWLEDGES READING AND RECEIVING THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE.

PATIENT SIGNATURE (PARENT IF MINOR): DATE: