

PLEASE ANSWER THE FOLLOWING QUESTIONS:

TODAY'S DATE _____

Mr. Mrs. Ms. Dr. Last Name _____ First _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail _____ Date of Birth _____ Soc. Sec. # _____
Occupation _____ Employer _____

ARE YOU A NEW PATIENT? YES NO

HOW WERE YOU REFERRED TO US?

Yellow Pages Saw the Office Recall Notice Coupon/Mailer Insurance Co. Website Other Internet _____
 Other _____ Friend/Relative: Name _____

Date of last eye exam? _____ Age of present glasses? _____ Age of present contact lenses? _____
Do you sleep in your lenses? Yes No How often do you dispose of your contacts? _____
Interested in: New contact lenses? Yes No Laser surgery? Yes No Sports eyewear? Yes No

INSURANCE ASSIGNMENT AND HEALTH AUTHORIZATION

Your signature below signifies that you consent to the use and disclosure of your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. You have the right to ask us to restrict the use of this information.

I assign my insurance benefits payable to **Dr. Henslick** Signature _____

Please note: In the event that benefits aren't paid by the insurance carrier, the entire balance is your responsibility.

VISION INSURANCE

Vision Service Plan (VSP) Medi-Cal Union Medicare

Other Insurance (please specify) _____

IF INSURED IS OTHER THAN SELF, LIST **INSURED** INFORMATION: Relationship _____

Name _____ Birthdate _____ Soc. Sec. # _____

PRIMARY MEDICAL INSURANCE

HMO PPO POS Other (please specify) _____

Carrier _____ ID# _____ Phone _____

Name of family Doctor _____ Phone _____

DO YOU OR YOUR FAMILY HAVE (please circle):

Cataracts?	Self	Family	None
Glaucoma?	Self	Family	None
Eye Surgery?	Self	Family	None
Headaches?	Self	Family	None
Diabetes?	Self	Family	None
High Blood Pressure?	Self	Family	None
Thyroid Problems?	Self	Family	None
Cataract Surgery?	Self	Date(s)	_____
Other Eye Surgery or Condition?	_____		
Dry or irritated eyes?	Occasionally	Frequently	

DO YOU (please circle):

Drink Alcohol?	Yes	No
Smoke Tobacco?	Yes	No
Use Other Substances?	Yes	No
Allergies	_____	
Medications	_____	
Hobbies	_____	
Computer use per day?	_____ hours	

HOW WOULD YOU LIKE US TO CONTACT YOU IN THE FUTURE: Phone Mail Email _____

Date _____ Changes _____ Sig _____

