PATIENT FORM

FRASER® OPTICAL

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method home | cell phone | email | text | other

Patient Social Security Number

Date of Birth

Male / Female

Occupation / Employer

Marital Status Married | Single | Divorced | Legally Separated | Widowed

Language

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy# and Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member spouse | child | other (please explain)

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy# Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	Yes	No
Crossed Eye	Yes	No
Glaucoma	Yes	No
Lasik or RK	Yes	No
Lazy Eye	Yes	No
Macular degeneration	Yes	No
Retinal Detachment	Yes	No

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes or Floaters
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or gritty Feeling

MEDICAL HISTORY

Have you experienced,or been treated for, any of the following? Circle all that apply.

Allergies	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Kidney Disease	Yes	No
Lupus	Yes	No
Neurological Conditions	Yes	No
Psychiatric Disorder	Yes	No
Seizures	Yes	No
Roseacea	Yes	No
Stroke	Yes	No
Thyroid Dysfunction	Yes	No

Current Medications (prescription and over-the counter and dosage)

Are you pregnant or nursing?	Yes	No
Do you smoke?	Yes	No

PATIENT FORM

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or insurance status. I authorize payment of insurance benefits to the doctor, unless I have paid my account in full. *I am responsible for any fee not covered by my insurance, or for any co-payments, at the time services are rendered.*I also understand that, regardless of my insurance status I am ultimately responsible for the balance. NOTE : Financial responsibility for minors is that of the custodial parent.

Signature of Patient _____ Date _____

Signature of Patient Representative _____

Relationships (if signed by Representative) _____

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (Print):_____ Date:_____

Signature Of Patient / Pt Representative (if patient is a minor or an adult unable to sign this form):_____

Relationship of Patient Representative to Patient:_____