Welcome to our Office

Last name:_____ First name: _____ MI _____ Date: _____

Address: _____ Telephone (H): _____ DOB: _____

City, ST ZIP _____ Telephone (Cell): _____ Age: _____

Telephone(Work): _____

SSN: _____- _____ - _____ Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐

Occupation (Grade): _____ Employer: _____

If child, Parent's Name: _____ Email address: _____

Emergency Contact: _____ Telephone: _____

Medical History

What is your general health? _____ Height: _____Weight: _____

Do you have any problems with any of these systems?

Respiratory	Y/N	Cardiovascular	Y/N	Gastrointestinal	Y/N	Nervous	Y/N
Mental	Y/N	Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine	Y/N
Blood/lymph	Y/N	Musculoskeletal	Y/N	Immulologic	Y/N	Skin	Y/N

Please Explain _____

Diabetes Y/N Date of Diagnosis _____ Current Medications: _____

High Blood Pressure Y/N Date of Diagnosis _____ _____

Medication Allergies: _____ _____

Have you had any operations? _____ Date: _____ _____

Do you use cigarettes/tobacco? Y/N Alcohol? _____ Other substances? _____

Name of Family Doctor: _____ Date of last visit: _____

Family History

Diabetes Y/N _____ High Blood Pressure Y/N _____ Glaucoma Y/N _____

Macular Degeneration Y/N _____ Cataracts Y/N _____ Other eye conditions _____

Ocular History

Have you had any eye injuries or operations? Y/N _____ Date _____

Do you have Glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Allergies? Y/N Other? Y/N _____

Do you have blurred vision? ☐ At distance ☐ At near ☐ Both Do you use eye drops? Y/N _____

Do you wear glasses? Y/N Contact lenses? Y/N Type _____

Do you plan on selecting new glasses today? Yes No

Would you like to try contact lenses today? Yes No ☐ Need to Reorder

How did you hear about our office? ☐ Returning Patient ☐ Phone Book ☐ Newspaper ☐ Insurance ☐ Internet ☐ Location

☐ Friend/Family Referral _____

Notice of Privacy Practices available upon request:

I acknowledge that I was offered a copy of Dr. Alex J Robinson's Notice of Privacy Practices

Authorization/Signature on File:

I certify that I have read and understand the above information and have accurately answered the questions to the best of my knowledge. I authorize the eye doctor to release any information required to process my insurance claim, or insurance claim for my child. I also authorize my insurance benefits be paid directly to the eye doctor and understand that I am financially responsible for any noncovered or denied services. Any copy of this authorization shall be as valid as the original.

Signature: _____ Date: _____ Doctor's initials _____