Patient History— This form is required to be updated by insurance companies each time the insurance is utilized to pay for your services. Insurance Companies now offer language assistance as needed. Y or N or Family Member

Last Name___________________________________ First Name_____________________________ Sex: F M

Address_____________________________________ Date of Birth_________ Age_____ Last 4 of SS#_______

_____________________________________ Primary Vision Insurance__________________________

______________________________________ Insured ID number_______________________________

Cell Phone Number____________________________ Insured Name and Relation________________________

Home Phone__________________________________ Second Vision Ins and ID__________________________

Drivers License #______________________________ Fulltime Student: Y or N, College ID________________

Employer____________________________________ Occupation______________________________________

Medical Insurance______________________________ Medical Doctor Name_____________________________

Last Eye Exam ___________________ Email address:____

Please circle: Wears glasses for distance, near, both or none Wears Contacts Y or N Type_________________

Reason for visit:____

Your Medical Health History: Circle response

High Blood Pressure: Y or N Diabetes: Y or N, Type_____ High Cholesterol: Y or N Cancer: Y or N

Heart Issues: explain if Y_________________ Arthritis: Y or N Other medical Issue_____________________

Allergies: Seasonal: Y or N Other allergies_________________ Pregnant Y or N

Medications:____

____

Medication Allergies:____

Consumption of alcohol is: frequent social none Smoker: Packs a day______ none

Your Current Eye Conditions: Circle response

Cataract: Y or N Glaucoma: Y or N Macular Degeneration: Y or N Lazy Eye: Y or N

Retinal issues: Y or N explain___________________ Dry Eye: Y or N Redness: Y or N Burning: Y or N

Have you had any eye injuries: Y or N explain____

Have you had any eye surgeries: Y or N explain____

Family Eye and Medical History: For Yes indicate relationship:

Cataract______________ Glaucoma________________ Macular Degeneration________________

Retinal Detach or Disease__________________ High Blood Pressure______________Stroke_________

Diabetes__________________HighCholesterol__________________Cancer____________Arthritis____ I certify the above is accurate to the best of my knowledge. I understand that providing inaccurate information is detrimental to my health. I am giving permission for **Mintz Family Optometry** to bill my insurance and realize that any portion not paid will be my responsibility.

Print Name____ Staff review___

Signature____date_______________ Dr reviewed___

I have reviewed prior info as accurate and give permission to bill my insurance.

Next Year Review and Added Info____Initials____ and Date___________

Next Year Review and Added Info____Initials____and Date___________