PLEASE PRINT

PATIENT INFORMATION

NAME_____AGE_____BIRTH DATE

ADDRESS_____CITY_____ZIP

PHONE#_____SOCIAL #

OCCUPATION_____HOBBIES

NAME OF PARENT OR SPOUSE

HEALTH HISTORY NAME OF FAMILY DOCTOR

1. Reason for eye exam today
2. Age of present glasses_____Last eye exam
3. Circle if you have any of the following
   - High blood pressure
   - Diabetes
   - Lung problems
   - Cataracts
   - Glaucoma
   - Eye surgery
   - Eye injuries
   - Allergies
   - History of family eye disease
   - Allergies to medications
   - Pregnancy/Nursing
4. Medications you are currently taking
5. Is this exam for contact lenses circle Yes/No

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Scott Armer O.D., including physician services. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services. I authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due in NON DSHS claims. I authorize the the doctor or insurance company to release any information required for this claim. I have read and understand the posted NOTICE OF PRIVACY and can have a copy of it at my request.

X_____DATE_____.

PATIENT SIGNATURE