

Marvin L. Baza, Jr., O.D.

UPDATE & INSURANCE INFORMATION: DATE: _____

PATIENTS NAME: _____

PARENT OR GUARDIAN IF PATIENT IS MINOR:

ADDRESS: _____

_____ E-MAIL _____

PATIENTS D.O.B.: _____ Is patient full time student? yes no

DRIVER'S LICENSE # _____

SOCIAL SECURITY # _____

MARITAL STATUS: married single divorced widowed separated

TEL. HM: _____ WK: _____ CELL: _____

EMPLOYER: _____ RETIRED? YES NO

OCCUPATION: _____

INSURANCE CO. NAME: _____

INSURANCE I.D. # _____

GROUP # _____

INSURANCE COMPANY PHONE # _____

INSURED'S NAME: _____ RELATIONSHIP TO PT. _____
(IF DIFFERENT THAN PATIENT)

D.O.B.: _____

DRIVER'S LICENSE # _____

SOCIAL SECURITY # _____

TELEPHONE: HM: _____ WK: _____ CELL: _____

EMPLOYER: _____

INSURED'S I.D. # _____ GROUP# _____

I, the undersigned, hereby acknowledge that I am responsible for all charges made at each visit unless other arrangements have been made in advance. I hereby authorize benefits be paid directly to the physician. I also authorize the physician to release any information required to process my insurance claims. I, the undersigned, authorize the release of my records to my referring and or primary care physician.

PATIENT'S SIGNATURE: _____
(PARENT OR GUARDIAN, IF MINOR)

TODAY'S DATE _____

PERSONAL INFORMATION

PATIENT NAME MR. ___ MISS ___ MRS. ___ MS ___		SOC. SEC. #	DRIVER'S LICENSE #	BIRTH DATE
ADDRESS		CITY	STATE	ZIP
HOME PHONE	BUSINESS PHONE	OCCUPATION	EMPLOYER	
NAME OF PARENT OR SPOUSE	E-MAIL	GRADE IF STUDENT	DO YOU USE A COMPUTER SCREEN? <input type="checkbox"/> NO <input type="checkbox"/> YES; HOW MUCH	
METHOD OF PAYMENT <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHECK <input type="checkbox"/> CASH <input type="checkbox"/> CREDIT CARD		HAVE WE SEEN OTHER MEMBERS OF YOUR FAMILY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHOM?		

MEDICAL HISTORY

NAME OF FAMILY PHYSICIAN & CITY	NAME OF LAST EYE DOCTOR & CITY
LIST ANY MEDICAL CONDITIONS YOU ARE BEING TREATED FOR	WHEN WAS YOUR LAST EYE EXAM?
LIST MEDICATIONS YOU ARE TAKING (INCLUDE HORMONES/BIRTH CONTROL & NON-PRESCRIPTION MEDS)	
LIST ANY MEDICATION ALLERGIES	DO YOU USE?: CIGARETTES/TOBACCO Y <input type="checkbox"/> N <input type="checkbox"/> ALCOHOL Y <input type="checkbox"/> N <input type="checkbox"/> OTHER SUBSTANCES Y <input type="checkbox"/> N <input type="checkbox"/>
CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU	
<input type="checkbox"/> DIABETES	<input type="checkbox"/> ALLERGIES
<input type="checkbox"/> HEADACHES	<input type="checkbox"/> CANCER
<input type="checkbox"/> HEAD TRAUMA	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> LUNG DISEASE
<input type="checkbox"/> OTHER; PLEASE LIST _____	<input type="checkbox"/> HEART DISEASE
	<input type="checkbox"/> VASCULAR DISEASE
	<input type="checkbox"/> ARTHRITIS
	<input type="checkbox"/> HIGH BLOOD PRESSURE
CHECK ANY EYE CONDITIONS THAT APPLY TO YOU	
<input type="checkbox"/> EYE DISEASE	<input type="checkbox"/> EYE SURGERY
<input type="checkbox"/> TURNED EYE	<input type="checkbox"/> LAZY EYE
<input type="checkbox"/> OTHER; PLEASE LIST _____	<input type="checkbox"/> GLAUCOMA
	<input type="checkbox"/> VISION THERAPY
	<input type="checkbox"/> CATARACTS
	<input type="checkbox"/> GLASSES
CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS	
<input type="checkbox"/> CATARACTS	<input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> OTHER EYE DISEASES _____	<input type="checkbox"/> DIABETES
<input type="checkbox"/> OTHER INHERITED CONDITIONS; _____	<input type="checkbox"/> HEART DISEASE
	<input type="checkbox"/> HIGH BLOOD PRESSURE

CONTACT LENS HISTORY

<input type="checkbox"/> Never worn contacts	Contact Lens Type - _____
<input type="checkbox"/> Not interested in contacts	How long - _____
<input type="checkbox"/> Would like to know my contact lens options	Solutions - _____
<input type="checkbox"/> Allergic to lens care solutions; _____	_____
<input type="checkbox"/> Problems with contacts: _____	_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

<input type="checkbox"/> MAILOUTS	<input type="checkbox"/> PHONE BOOK	<input type="checkbox"/> NEWSPAPER	<input type="checkbox"/> TELEVISION	<input type="checkbox"/> LOCATION
<input type="checkbox"/> DIRECT REFERRAL; NAME _____				

FOR OFFICE USE ONLY: _____
