It is patients responsibility to inform front desk of any insurance or changes with insurance

Patient Information:

Full Name (Please print) _____ DOB_____

Address _____ City _____ State ___ Zip Code _____

Home # _____ Work # _____ Cell # _____

EMAIL _____ Referred By _____

Vision/ Medical Insurance Company: _____

Occupation _____ Subscriber ID or SS# _____

Medical History:	Yes	No	**Family History:**	Yes	No	Relation
Diabetes	☐	☐	High Blood Pressure	☐	☐	_____
Cardiovascular Problems	☐	☐	Macular Degeneration	☐	☐	_____
Respiratory Problems	☐	☐	Diabetes	☐	☐	_____
High Cholesterol	☐	☐	Retinal Detachment	☐	☐	_____
Skin Conditions	☐	☐	Glaucoma	☐	☐	_____
Psychological	☐	☐	Cataracts	☐	☐	_____
Endocrine (Glands)	☐	☐				
High Blood Pressure	☐	☐	**Height:** _____			
			Weight: _____			

Ocular History:	Yes	No	
Eye Operations	☐	☐	Type _____ Date _____
Eye Injuries	☐	☐	Type _____ Date _____
Glaucoma	☐	☐	
Cataracts	☐	☐	
Dry Eye	☐	☐	
Glasses	☐	☐	Date of last exam _____
Contacts Lenses	☐	☐	

Current Medications: _____

Allergies to Medications: _____

Smoker ☐ Yes ☐No

Consume Alcohol ☐ Yes ☐ No Drinks per week _____

Primary Care Physician: _____ Telephone _____

I hereby grant permission for Dr. Richard Zobel to exchange information with my insurance company concerning my history/ results of my examination diagnosis/ treatment. I hereby assign all medical benefits to which I am entitled. I understand that I am financially responsible for all charges whether paid by said insurance. It will be patients responsibility to provide our office with any required referrals. I authorize this office to release any information needed to determine these benefits for related service. Patients without insurance are responsible for all charges at time of visit.

Patients Signature _____ **Date** _____