

***Welcome to our office!*** To better serve your specific needs, please complete all parts of the form.

Patient Name (please print) \_\_\_\_\_ Appointment Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ M or F Name of parent or guardian \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

**INSURANCE INFORMATION** (complete only if you are using insurance)

Vision Insurance? Y / N Type \_\_\_\_\_ Name of Insured \_\_\_\_\_

Patient relationship to insured \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Insured SSN \_\_\_\_\_

Patient SSN \_\_\_\_\_

I request that payment of authorized Medicare benefits or other insurance be made either to me or on my behalf to Mary Jo Baize, O.D., P.A., for services furnished me by the doctor. 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 the benefits payable for related services. I also understand that if my insurance company does not provide payment, I will be responsible and billed for said services.

Lifetime Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medical Information:** Do you, or any blood relatives, have problems with any of these systems? Please check all that apply. **P= Patient F= Family**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> <input type="checkbox"/> Diabetes        | <input type="checkbox"/> <input type="checkbox"/> Mental               |
| <input type="checkbox"/> <input type="checkbox"/> Ear/Nose/Throat  | <input type="checkbox"/> <input type="checkbox"/> Nervous System  | <input type="checkbox"/> <input type="checkbox"/> Blood/Lymph          |
| <input type="checkbox"/> <input type="checkbox"/> Cardiovascular   | <input type="checkbox"/> <input type="checkbox"/> Genitourinary   | <input type="checkbox"/> <input type="checkbox"/> Allergic/Immunologic |
| <input type="checkbox"/> <input type="checkbox"/> Respiratory      | <input type="checkbox"/> <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> <input type="checkbox"/> Sleep Apnea          |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> <input type="checkbox"/> Skin            | <input type="checkbox"/> <input type="checkbox"/> Other                |

Do you smoke? Y / N How Much? \_\_\_\_\_

Do you take medication Y / N Please list names \_\_\_\_\_

Allergic to any medications? Y / N Please list \_\_\_\_\_

**Ocular History:** Do you (or any blood relatives) have any of these conditions? Please check.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> <input type="checkbox"/> Color Blindness    | <input type="checkbox"/> <input type="checkbox"/> Wear Glasses        |
| <input type="checkbox"/> <input type="checkbox"/> Cataracts            | <input type="checkbox"/> <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> <input type="checkbox"/> Wear Contact Lenses |
| <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> <input type="checkbox"/> Eye Surgeries      |   |
| <input type="checkbox"/> <input type="checkbox"/> Strabismus/ Lazy eye | <input type="checkbox"/> <input type="checkbox"/> Eye Injuries       |   |

Reason for today's visit \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

**I now experience:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Eyestrain        | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Glare                      |
| <input type="checkbox"/> Blur at Distance | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Eye Pain                   |
| <input type="checkbox"/> Blur at Near     | <input type="checkbox"/> Dry Eyes        | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Watery Eyes      | <input type="checkbox"/> Pressure        | <input type="checkbox"/> History reviewed by doctor |
| <input type="checkbox"/> Itchy Eyes       | <input type="checkbox"/> Flashing lights |   |
| <input type="checkbox"/> Floaters         |  |   |