Date: _____

Welcome to Blahnik Vision Center

Reason for today's visit: _____

Patients with scheduled appointments will be seen first. If you do not have an appointment please be patient, you will be worked in as soon as possible. Please note that doctors fees are to be paid at the time of the exam. We accept Cash, Check, Visa, MasterCard, Discover & American Express.

Patient Information

Title **Last** **First** **Middle**

Mr. __ Mrs.__Ms._____

Address _____

City, State, ZIP_____

Primary Phone# (_____)_____ Secondary Phone#(_____)_____

Date of Birth_____ Age_____ Sex: M _____ F _____

Occupation: _____

Patient Status: Married ____ Single____ Other_____

Will you be getting contact lenses today? (If yes, additional fees may apply) _____

Insurance Information

Type of Medical / Vision insurance carried, (if any):_____

Policy Holder's Name: _____

Policy Holder's Social Security #:_____

Policy Holder's Date of Birth: _____

Relationship to Policy Holder: _____

***If you have your medical & vision insurance cards, we will need to make copies. Thanks.**

_____

Patient/Guardian Signature

Visual & Medical History

Approximately how long has it been since your last eye exam?

_____

Current medications (if unsure of name, please tell us what it is used for): _____

_____

_____

Are you allergic to any medications? If yes, please list them: _____

_____

Do you smoke? _____

Please check any condition that applies to yourself or any member of your immediate family of blood relations:

	Self	Family		Self	Family
Diabetes	___	___	Glaucoma	___	___
High Blood Pressure	___	___	Macular Degeneration	___	___
Respiratory Disorders	___	___	Cataracts	___	___
Thyroid Disorders	___	___	Retina Detachment	___	___
Arthritis	___	___	Double Vision	___	___
Crossed or Lazy Eyes	___	___	Stroke	___	___
Head or Eye Injury	___	___	Headaches	___	___
Eye Surgery	___	___	Other _____		