Peepers

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr ❑ Miss ❑ Mrs ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Street Address			**Birth Date** / /	Age	Sex ❑ M ❑ F
City	State	ZIP Code		Home Phone No. ( )
Primary Insurance	ID #	Primary Name on Insurance	Primary's Birth Date / /	

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. ❑ Optical. ❑ Insurance ❑ Doctor

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Advertising ❑ Other _____

Other Family Members Seen Here _____

Medical History

BP, CANCER, THYROID, DIABETES & LIST OF ORAL MEDICATIONS

Ocular History

Ever had an eye injury or surgery	❑ Yes	❑ No	Please describe:		
Do you have any of the problems with current glasses?	❑ Blurry Vision	❑ Double Vision	❑ Headaches	❑ Tearing	❑ Spots
❑ Light sensitive	❑ Trouble Near	❑ Trouble Far	❑ Glaucoma	❑ Cataracts	Other please describe below:

Eyewear Usage

Do you wear your glasses for...	❑ Driving	❑ Reading	❑ Playing Golf	❑ All the time
Do you drive	❑ Yes	❑ No	❑ Glare at night?	
Do you use a computer	❑ Yes	❑ No	Hours per day_____	

Do you have any specific visual challenges or concerns we should know about?

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Peepers or my insurance company to release any information required to process my claims. By signing this form, you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices (HIPAA).

X _____

PATIENT/GUARDIAN SIGNATURE DATE