Medical History Questionnaire

Please Present all Insurance cards at time of service

Date____/____/____

Mr. Mrs. Ms. Dr. Patient Name: _____

E-Mail: _____

Parent or Guardian: _____ Last Eye Exam: ___/___/____

Street: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip: _____

Birth Date: _____/_____/_____ Age_____ **Last Four** of Social Security #: _____

Occupation: _____ Employed By: _____

Medical Insurance: _____ ID# _____ Group#_____

Vision Insurance: _____ ID# _____ Group#_____

Medical History:

Do you have any allergies to medications? No Yes If yes, please explain _____

_____

Please list **medications** you are taking (including aspirin, over the counter medications and home remedies):

_____

_____

Have you or anyone in your family been diagnosed with **(circle)**:

GLAUCOMA MACULAR DEGENERATION DRY EYE OTHER:_____

I have been presented with the Notice of Privacy Policy of Facchiano / Wooldridge Optometry, and have been offered a copy of such a policy to keep for my records. I understand co-payment or any balance not paid by insurance is expected at the time of Service. I give consent for Facchiano / Wooldridge Optometry to use my medical information solely for the purpose of medical treatment, consultation, insurance billing, claims payment, or other lawful purpose.

_____

Print Name **Sign Name** **Date**