WELCOME! Thank you for choosing our practice for your eyecare needs.
Please ask us if you need any assistance completing this form.

PATIENT INFORMATION

Full Name_____ Age_____ Sex_____ Race_____ Date_____
Address_____ City_____ Zip Code_____
Home Phone_____ Work Phone_____ Cell Phone_____
Birthdate_____ Marital Status_____ E-Mail_____
Preferred method of contacting you (circle one): Home Phone Cell Phone Email Texting OK? Yes No
SS #_____ Occupation_____ Employer/City_____
Family Physician_____ City_____ Phone_____
Whom may we thank for referring you to us?_____

RESPONSIBLE PARTY/INSURANCE INFORMATION

Name of person responsible for this account (if not patient)_____
Relationship to patient_____ Address (if different)_____
City_____ Zip Code_____ Home Phone_____ Work Phone_____

Vision Insurance_____	Medical Insurance_____	Secondary Insurance_____
ID #_____	ID #_____	ID #_____
Member_____	Member_____	Member_____
Insured's Birthdate_____	Insured's Birthdate_____	Insured's Birthdate_____
Relationship to patient_____	Relationship to patient_____	Relationship to patient_____

EYE / HEALTH HISTORY

Reason for today's examination_____
When was your last eye exam?_____ Previous Eye Dr.'s name_____
Do you currently wear eyeglasses?_____Contact lenses?_____ Interested in LASIK?_____
Do you have special visual needs for occupation or hobbies?_____
Have you had any previous history of eye injury, infection, or surgery?_____
Do you suffer from eye dryness, irritation, itching, or burning?_____
Are you currently under the treatment of a physician for any reason?_____
Medications_____
Allergy to medications_____ Do you use cigarettes/tobacco?_____
Have you or any family member (genetic relative) had a history of the following?:

Diabetes_____	High Blood Pressure_____	Thyroid_____
Headache_____	Heart Trouble_____	Sinusitis_____
Cataracts_____	Retinal Problems_____	Glaucoma_____
Allergies_____	Turned/Lazy eye_____	Blindness_____

**I certify that I have read the above information and have accurately answered the questions to the best of my knowledge. I authorize Bogan Eyecare Center to release any information from the medical records of me or my dependent to third party payers and/or other health care providers. I authorize and request my insurance company to pay benefits directly to the doctor. I agree to be responsible for payment of all services rendered on my behalf or my dependent.*

PATIENT SIGNATURE_____ DATE_____