WELCOME TO THE OFFICE

Dr. Jaime Blyskal Marcolini, Dr. William R. MarcolinI, Dr. John Hnatyko, Dr. Mason Munn

Patient Name_____

Street_____

City_____ State_____ Zip_____

Home Phone_____

Cell Phone_____

Occupation (or Grade)_____
Date of Birth_____/_____/_____ Sex: Male / Female

E-mail Address_____

Are there any problems with your current contact lenses or glasses?_____

VERY IMPORTANT! New Patients Only!
Who may we thank for referring you to our office?
Name of friend or relative_____

INSURANCE INFORMATION

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____Date of birth___/___/___
Relationship to Patient_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____ Date of birth___/___/___
Relationship to Patient_____

I understand that it is not the responsibility of this office to know my insurance coverage. I am ultimately responsible for the payment of my medical bill in the event I have not met my deductible for the year, do not have routine vision coverage or I exceed the allowances of my insurance coverage. I understand that all co-pays, deductibles, contact lens service fees and Recommended Testing, not covered by most insurance, are to be paid in full today. I understand that my information will be released to third party insurers/payers.

_____ Date_____/_____/_____
Signature

FAMILY MEDICAL/EYE HISTORY

Is there a family history of any of the following?

	Relationship
___ Blindness	_____
___ Cataracts	_____
___ Corneal Problems	_____
___ Glaucoma	_____
___ Lazy Eye	_____
___ Macular Degeneration	_____
___ Retinal Problems	_____
___ Diabetes	_____
___ Heart Disease	_____
___Other	_____

PATIENT MEDICAL/ EYE HISTORY

Name of Family Physician_____

Date of last physical exam_____

Date of last eye exam_____

Current Medications (prescription, over the counter, vitamins)

_____
_____
_____
_____
_____
_____
_____

Allergies to Medications: Yes No
Please list :
_____
_____
_____

	Yes	No
Eyes (Glaucoma, cataracts, retinal disease)		
Blurred Vision/loss of vision		
Double vision		
Dryness/sandy or gritty feeling		
Mucous discharge		
Redness/itching/burning/tearing		
Glare/light sensitivity		
Eye pain or soreness/ tired eyes		
Swollen eyelid/drooping eyelid		
Crossed eyes/ lazy eye/ amblyopia		
Flashes of light or floating spots in vision		
General Health		
Fever, weight loss, other		
Ear nose throat (sinus infection,dry mouth)		
Cardiovascular (high blood pressure)		
Respiratory (asthma, emphysema,etc.)		
Gastrointestinal (ulcers, intestinal disease)		
Genital, Kidney, Bladder		
Muscles, Bones, Joints (arthritis)		
Skin(acne, warts, skin cancer etc.)		
Neurological (Multiple sclerosis etc.)		
Psychiatric (anxiety, depression, other)		
Endocrine (diabetes, thyroid disorder etc.)		
Blood/lymph (cholestoremia, anemia etc.)		
Allergic/Immunologic (hay fever,lupus etc.)		

Do you smoke? Yes No or Do you drink alcohol? Yes No

Do you currently wear contact lenses? Yes No

Are you interested in Lasik? Yes No