Last Name:	First Name:	Middle Initial:	Birth date:
Home Address: Apt. #	City:	State:	ZIP:
Home Phone:	Work/Day Phone:	Cell Phone:	
Email:	Occupation:	Insurance:	
Parent/Guardian Name: (if under 18)	Male Female		
Primary Care Doctor:	Race: (optional)		

Your Health History:

	YES	NO
Diabetes		
High Blood Pressure		
Heart Disease		
Lung Disease		
Thyroid Disease		
Cancer (where?)		
Infectious Disease		
Liver Disease		
Autism Spectrum		
Lazy Eye		
Crossed Eyes		
Eye Injury		
Eye Surgery		
Cataracts		
Glaucoma		
Other Eye Diseases		
Migraines/Headache		

	YES	NO
Flashes in eye		
Floaters		
Double Vision		
Eye Pain		
Changing Vision		
Vision Blackout		
Halos on lights		
Light Sensitive		
Eyelid Bump		
Discharge		
Itchy Eyes		

Dry Eyes		
Watery Eyes		
Tired Eyes		
Red Eyes		
Crusty Lashes		

	YES	NO
Are you Pregnant?		
Do you smoke?		
Do you drink alcoholic beverages?		
Wear glasses?		
Worn ***prescription*** contact lenses?		

Please list your meds: or N/A
(or provide a copy)

Are you allergic to any medications?	**YES**	**NO**
Which ones?		

Family **Health History:**	YES	NO
Diabetes		
Glaucoma		
Eye/Retina Disease		
Blindness		

How did you hear about us? (circle one)	
Friend	Website, facebook, Google
Postcard	Walk-in
Name of your friend who referred you:	

Authorization to Bill Insurance: I hereby give my consent for Dr. Ramsey to bill my insurance carrier for the services rendered. In addition, I agree to pay any deductible or uncovered charge in accordance with my health care plan.

_____ _____
Patient/Guardian Signature Date

Notice of Privacy Policy Acknowledgement: I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Sign _____ Date _____