

PATIENT INFORMATION**PLEASE PRINT**

LAST NAME		FIRST		PREFERRED NAME		M / F
ADDRESS			CITY		STATE	ZIP
TELEPHONE H ()		C ()		W ()		BIRTHDATE / /
SOCIAL SECURITY NO. (IF OVER 18)			EMPLOYERS NAME			
VISION INSURANCE		ID #		MEDICAL INSURANCE		ID #
MEMBERS NAME			RELATIONSHIP TO PATIENT		MEMBERS BIRTHDATE / /	
PERSON RESPONSIBLE FOR PAYMENT						
ADDRESS IF DIFFERENT THAN ABOVE						
SIGNATURE					DATE	

Do you or any family member have any of the following conditions?

diabetes	No	Yes	Who? _____
high blood pressure	No	Yes	Who? _____
glaucoma	No	Yes	Who? _____
macular degeneration	No	Yes	Who? _____
retinal detachment or degeneration	No	Yes	Who? _____
thyroid problems	No	Yes	Who? _____
any other health problems	No	Yes	Who? _____

Are you allergic to any medication? No Yes Please list _____

Are you taking any medication? No Yes Please list _____

Have you ever had an eye disease, injury, or surgery? No Yes Please list _____

Do you have trouble with night vision? No Yes
 Have you ever worn contact lenses? No Yes
 Do you now wear contact lenses? No Yes

Do you use cigarettes/tobacco? No / Yes Alcohol No / Yes Other substances? No / Yes

I acknowledge that I received a copy of the Notice of Privacy Practices of Drs. Johnson, Schoepke, and Todd

Signature _____ Date _____
 (Signature of parent if patient is under 17)