WELCOME

Denise Carter, O.D. * Optometry and Contact Lenses

Please Print and Fill Out Completely

Name: Date: SSN

First Middle Last

Address City State Zip

Age: Birth date Home Phone: Work Phone:

Born in (State): E-mail address:

Primary language: Race: Ethnicity: :

Circle One: Minor Married Divorced Widowed Single Separated

If Minor, name of parent or guardian:

Your Employer Occupation

Insurance Company (if any): Name of insured: D.O.B.:

Who were you referred by:

HEALTH HISTORY

Please list ALL medications you are currently taking:

Name of previous eye doctor: Date of last exam:

Do you or anyone in your immediate family have a history of the following:

Blindness Cataracts Diabetes Glaucoma Heart Condition High Blood pressure Macular Degeneration Thyroid Turned or "lazy" Eye

List any allergies you have:

Have you ever had any of the following conditions involving your eyes?

Eye surgery Sensitivity to Light Eye infection or disease Eye injury Floaters or Spot Eye Strain

Double Vision Medical Treatment Poor Distant or Near Vision Severe Pain Eyes Burn, Itch or Water

Do you currently wear glasses: Yes No

When do you wear your glasses?

All the time Reading/Near work Work Safety Distance Tasks Only Computer work Other:

Have you ever worn contacts? Yes No

Are you interested in wearing contacts lenses? Yes No

Do you work at a computer or video display terminal? Yes No

What hobbies or sports do you participate in?

PAYMENT DUE AT TIME OF SERVICES, PLEASE

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I hereby authorize Dr Denise W. Carter to furnish information to insurance carriers concerning my condition, and I hereby assign to Dr. Carter all payments for medical services rendered to myself or to my dependents.

Date: **Signature**