Donald P. Humphrey, O.D. Michael L. Maggard, O.D.

WELCOME TO OUR OFFICE! To help us give you the best possible eye care, please complete the following:

Date _____

Patient's Name Rev. Miss Dr. Mrs. Ms. Mr. _____ Age _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Permanent Address (if different) _____

_____ State ___ Zip _____ Cell No. _____

Birthdate _____ Sex _____ SSN _____

If Child, Father's Name _____

Father's Employer _____ Bus. Phone _____

Mother's Name _____

Mother's Employer _____ Bus. Phone _____

Child School _____ Grade _____

Patient's Employer _____ Bus. Phone _____

Spouse's Name _____ Employer _____ Bus. Phone _____

Referred by _____ Family Doctor _____

INSURANCE INFORMATION

Medicare # _____ Medicaid # _____

Other Ins. _____

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me by Dr. Maggard or Dr. Humphrey to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Responsible Person Signature

Please check your preferred method of payment:

Check/Cash _____ Credit Card _____ Third Party / Insurance _____

Please Turn Over

HEALTH HISTORY

GENERAL HEALTH:

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

			How Long				How Long
High Blood Pressure	no	yes	_____	Thyroid Disease	no	yes	_____
Heart Trouble	no	yes	_____	Dizziness	no	yes	_____
Kidney Trouble	no	yes	_____	Sinus	no	yes	_____
Emphysema	no	yes	_____	Depression	no	yes	_____
Chronic Bronchitis	no	yes	_____	Sleeplessness	no	yes	_____
Shortness of Breath	no	yes	_____	Seizures	no	yes	_____
Asthma	no	yes	_____	AID/HIV	no	yes	_____
Headaches	no	yes	_____	Hepatitis	no	yes	_____
Diabetes	no	yes	_____	Tuberculosis	no	yes	_____
Arthritis	no	yes	_____	Alcohol/Substance Abuse	no	yes	_____
Stroke	no	yes	_____	Pregnant Now?	no	yes	_____

List any medication allergy or other allergy: _____

List medications you are now taking: Reason:

_____ _____

_____ _____

_____ _____

_____ _____

EYE HEALTH:

Do you or a blood relative have any of the following? (Circle any that apply)

Glaucoma	no	yes	relative	Cataracts	no	yes	relative
Retinal Detachment	no	yes	relative	Eye Allergies	no	yes	relative
"Lazy" or Crossed Eye	no	yes	relative	Diabetic Eye Disease	no	yes	relative
Macular Degeneration	no	yes	relative	Eye Cancer	no	yes	relative
Other Eye Disease: _____					no	yes	relative

Have you had any eye surgery or eye injury? no/yes If yes:

Type: _____ Date: _____ Surgeon: _____ Rt Eye Lt Eye

_____ _____ _____ Rt Eye Lt Eye

Do you wear glasses? no/yes When was your last exam? _____

Do you wear contacts? no/yes Type? Disposible Rigid Soft

Would you like to be fit or refit with contact lenses? no/yes

Would you like to have current contact lens prescription updated: no/yes

DATE	C.V.C.	REVIEWED BY

☐ Michael L. Maggard, O.D.
☐ Donald P. Humphrey, O.D.