Last Name: First Name: MI: Current Date / /

Medical/Vision Insurance Information

(Patient Demographic Tab)

Primary Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Secondary Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Tertiary Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Vision Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Worker's Compensation Information

Date of Injury	Employer Name	Employer Representative Authorizing Treatment		
Representative Phone # ( ) -	Employer Street	Employer City	Employer State	Employer Zip
Insurance Carrier	Insurance Street	Insurance City	Insurance State	Insurance Zip
Employer Insurance Phone		Policy #		

Medical Records Information

Medications – Please list all of your current medications, including over the counter, herbals and supplements.
(Meds Tab)

Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other
Medication Name or Other	Date Started (mm/dd/yyyy)	Use or Other

Allergies (Meds Tab)

Name of Allergy or Other	Reaction	Severity	Onset	Type
Name of Allergy or Other	Reaction	Severity	Onset	Type
Name of Allergy or Other	Reaction	Severity	Onset	Type
Name of Allergy or Other	Reaction	Severity	Onset	Type
Name of Allergy or Other	Reaction	Severity	Onset	Type

Surgeries (ROS Tab)

Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure or Other
Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure or Other
Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure or Other
Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure or Other
Date of Surgery (mm/dd/yyyy)	Surgeon	Name of Procedure or Other

General History (Chief Complaint Tab)

Who is your Primary Care Physician?	Last Visit to PCP	Reason for Visit to PCP
Last Eye Exam (mm/dd/yyyy)	Dr. Last Eye Exam	