

Welcome To Our Office !

Shannon L. Compton, O.D. & Associates, P.C.

Thank you for choosing our practice for your eye care. Please complete this form, front and back.

Name _____ Date _____
First M.I. Last
Mailing Address _____ City _____ State _____ Zip _____
Street Address if different from mailing address.
City _____ State _____ Zip _____
Preferred First Name or Nickname _____ Social Sec # _____ Birth Date _____
Home Phone _____ Work Phone _____ Cell Phone (Opt) _____
Are you: () Minor () Married () Divorced () Widowed () Single
Your Employer _____ Occupation _____
Business Address _____ City _____
Spouse or Parent's Name _____ Work Place _____ Work Phone _____
If you are a student, name of school/college _____
Address _____
Whom may we thank for referring you to us _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for payment _____
Relationship to patient _____ Phone _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work Phone _____

MEDICAL INSURANCE INFORMATION

Insurance Co. _____ () Medicare () Medicaid () None
Name of Insured _____ Relationship to you _____
Name of Insured's Employer _____

DO YOU HAVE VISION CARE INSURANCE? (Pays on routine eye exams/glasses/contacts)

() Yes () No Insurance Co. _____
Name of Insured _____ Relationship to you _____
Name of Insured's Employer _____

OUR FINANCIAL POLICY

Eye exams and office visits are due, in full, at the time of visit. We will file your insurance for covered visits.
Glasses and contact lens orders require a 50% deposit before ordering. The balance is due in full when glasses or contacts are delivered. Order cannot be delivered until fully paid.

METHOD OF PAYMENT

() Cash () Check () Credit Card () Insurance () Medicare () Medicaid

I agree that I am responsible for full payment of each service or product which is not covered or fully paid by my insurer. I have read and understand the Financial Policy.

Signed _____

PATIENT HEALTH INFORMATION

Please provide the following information as completely as possible. The information is **confidential**, and all the information is necessary to meet Federal and Insurance requirements.

Name _____ Age _____

SPECIAL HOBBIES OR SPORTS _____

DO YOU WORK AT A COMPUTER? _____

Date of last eye exam _____ Doctor's Name _____

City _____

Do you, or have you ever worn () Glasses () Contact Lenses () Drug Store Readers () None

For: () Reading () Computer () Distance () All the Time () Other _____

How old is your current eyeglass or contact lens prescription? _____

Are you interested in **contact lenses**? _____ Are you interested in **laser vision correction**? _____

Please check any of the following problems you have with your VISION:

- | | |
|--------------------------------|---|
| () double vision | () halos around lights |
| () blurred vision at near | () spots before your eyes |
| () blurred vision at distance | () eye strain when reading or computer |
| () poor night vision | () trouble identifying colors |
| () flashes of light | () other (describe) _____ |

Please check any of the following problems you have with your EYES:

- | | |
|----------------------------|-------------------------------------|
| () pain in or about eyes | () discharge, pus, or matter |
| () light sensitivity | () recent eye injury within 1 year |
| () red or bloodshot | () eyelids red or swollen |
| () itching () burning | () other (describe) _____ |
| () eyes water excessively | |

Have you ever had any type of: eye surgery () yes () no eye injury () yes () no

Concerning your eyes, have you or any close relative ever had:

- () crossed eyes () glaucoma () cataracts () other _____

Do you have frequent or severe headaches? () yes () no Seizures? () yes () no

Do you use tobacco products? () yes () no Do you drink alcohol? () yes () no

Have you been or are you infected with: () Syphilis () HIV () Hepatitis

Please list any medications you are presently taking, including birth control pills and medications you can buy without prescription:

- | | | |
|----------|-----------------|-----------------|
| 1. _____ | What for? _____ | How long? _____ |
| 2. _____ | What for? _____ | How long? _____ |
| 3. _____ | What for? _____ | How long? _____ |
| 4. _____ | What for? _____ | How long? _____ |

Please list anything you are allergic to, including medications:

1. _____ 2. _____ 3. _____

Please check if you or any close relative have had any of the following:

- | | | |
|---------------------------------|---------|--------------------|
| asthma/respiratory difficulties | () you | () relative _____ |
| arthritis | () you | () relative _____ |
| blood disorders | () you | () relative _____ |
| diabetes | () you | () relative _____ |
| heart condition | () you | () relative _____ |
| high blood pressure | () you | () relative _____ |
| thyroid condition | () you | () relative _____ |

Your family physician's name _____ City _____

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