Hahn Price Vision Center

Welcome!! Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you!

Today's Date:_____

Name:_____ **Age:**_____ **DOB:**_____ **SSN:**_____ **Sex:** _____**Male** _____**Female**

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone Number:_____ **Cell Phone Number:**_____ **E-mail:**_____

If minor, Father's Name:_____ **Cell number:**_____ **E-mail:**_____

Father's Address if different from above:_____

If minor, Mother's Name:_____ **Cell number:**_____ **E-mail:**_____

Mother's address if different from above:_____

Spouse's name:_____ **Cell number:**_____

Employer/Occupation:_____ **Vision Insurance Plan:**_____ **Medical Insurance Plan:**_____

Subscriber's name, DOB, and SSN:_____

Last eye exam(please circle): 1yr 2yrs 3+yrs ago or 1st eye exam Previous location or Dr. Name:_____

PCP Name:_____ **Whom may we thank for referring you (First and Last Name):**_____

(Please check all that apply)

I am here for:
- ___Annual Eye Exam
- ___Diabetic Health Check
- ___Glasses
- ___Contact lenses
- ___Eye Infection/Injury
- ___Other
- ___Vision Therapy

I am experiencing:
- ___Distance problems
- ___Near problems
- ___Headaches
- ___Double Vision
- ___Dry Eyes
- ___Allergy Eyes
- _____Other

I have worn:
- ___Glasses
- ___Contacts
- ___Never worn glasses/contacts

Brand of Contacts Worn:_____ **Rx of Contacts R**_____ **L**_____

Are you pregnant:	Are you nursing:	Smoker:	Alcohol:	Height:	Weight:	Hours of Computer Use
___Yes	___Yes	___Yes	___Yes	_____	_____	_____
___No	___No	___No	___No			

Please list any allergies to medications:_____

Please list all medications you are taking including eye drops (Rx or over the counter):_____

_____

Do you, your grandparents, parents, or siblings have: (Please check all that apply)

	Self	Family	Relation		Self	Family	Relation
Diabetes	_____	_____	_____	Cataracts	_____	_____	_____
High Blood Pressure	_____	_____	_____	Glaucoma	_____	_____	_____
Thyroid	_____	_____	_____	Blindness	_____	_____	_____
Respiratory Problems	_____	_____	_____	Eye Injury	_____	_____	_____
Cancer	_____	_____	_____	Eye Surgery	_____	_____	_____
Migraines	_____	_____	_____	Macular Degeneration	_____	_____	_____
Heart Attack/Stroke	_____	_____	_____	Retinal Detachment	_____	_____	_____
Allergies	_____	_____	_____	ENT	_____	_____	_____
Muscular/Skeletal	_____	_____	_____	Neurological	_____	_____	_____
Psychological	_____	_____	_____	HIV	_____	_____	_____
Hepatitis C	_____	_____	_____	Other	_____	_____	_____

Please be advised if you are using insurance coverage for today's visit, you are responsible for any balances due after insurance, including deductibles. If you do not have insurance or if it is an insurance for which we are not a provider, please be aware that payment is expected at time of service. Balances thirty days past due are subject to 1.5% interest per month, late fees, and/or all collection fees. Your signature acknowledges this payment policy.
Thank you for coming to our practice! We are happy you have chosen our office for all of your eye care needs!

Signature_____ **Date**_____