WELCOME TO THE OFFICE

In order to help us render the proper optometric services to you, please be kind enough to answer the following questions. Many things have a direct bearing on the health of your eyes. Information you give us is strictly confidential, and will not be released to anyone without your written permission. Thank you for your cooperation.

Name_____ Sex_____ Age_____ Birthdate_____

Residence Address _____

Employed by _____ Occupation _____

Business Address_____

Home Phone #_____ Work Phone # _____

Spouse, Parent or Guardian _____

Whom may we thank for referring you to our office: Name _____

Address _____

General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Family Physician_____ Drug Store _____

Please list all medication you are currently taking, including non-prescription drugs. Medication: _____

_____

For what purpose:_____

Do you have or have you had any of the following? (Indicate with check mark)

☐ Circulatory problems	☐ Asthma or hay fever	☐ Nervous problems	☐ Blood pressure
☐ Heart problems	☐ Malignancies	☐ Arthritis	☐ Diabetes
☐ Epilepsy	☐ Pregnant	☐ Stroke	☐ Ulcer
☐ Sinus	☐ Allergies		

Approximate date of your last eye examination_____ Doctor _____

Have you worn glases before?_____ How long? _____

Have you worn contact lenses?_____ Are you interested in contact lenses? _____

Have you or any family members been treated for? (Indicate with check mark)

(1) Cataracts_____ (2) Glaucoma_____ (3) Eye muscle problems_____

Have you ever had any major eye disease?_____ If yes please explain:_____

_____

Have you ever had any severe injuries to your eyes?_____ If yes please explain: _____

_____

It is customary to pay for services when rendered. Cash, check and credit cards are accepted. If glasses or contact lenses are prescribed patient will pay a deposit upon initial exam and balance when prescription(s) are dispensed. Patient having valid insurance plans must make arrangements to have the correct form and pay the difference on the account. Should you have any questions regarding our office policy, please ask us so that any misunderstanding is avoided.

Please complete the following:

Type of insurance _____ Supplemental insurance_____

SS # of patient _____ SS # of insured _____

Name of insured _____

I hereby authorize Drs. Murray, Murray & Groves to furnish information to the insurance company upon their request, and payment made directly to the doctors office.

Signature_____

Thank you for allowing us the opportunity of caring for your eyes and vision. Your trust and confidence in us is greatly appreciated.

Drs. Murray, Murray and Groves