Insurance Company	Patient Name Last, First, MI	Nickname	Date
Date of Birth	Address, City, ST, Zip		Phone Numbers

Please check the information on this report for accuracy. Please make corrections and fill in any missing information. Thanks for your assistance.

NAME:				MARITAL STATUS	
ADDRESS:		**CITY**		**ST**	Zip
PRIMARY PHONE		**ALTERNATE PHONE**		**OTHER PHONE**	
BIRTHDATE				**SOCIAL SECURITY #**	
EMPLOYER/ SCHOOL				**FAMILY DOCTOR**	
OCCUPATIO N / GRADE:				**EMAIL ADDRESS**	
SPOUSE'S NAME				**SPOUSE'S EMPLOYER**	

INSURANCE INFORMATION

INS CO.	SUBSCRIBER	SUBSCRIBER ID	Birth Date

ACCOUNT RESPONSIBLE

RESPONSIBLE MEMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices for this office. □ Guardian

X ____ ________________

Printed Name Signature DATE

INSURANCE AUTHORIZATION

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to: McKenna Family Eye Care

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X ____ ________________

Printed Name Signature DATE

FINANCIAL RESPONSIBILITY

I hereby agree that in the event of non-payment I will be held liable for the collection costs, including but not limited to: collection agency fees, reasonable attorney fees (which you expressly agree that the reasonable attorney fees shall be the greater of: (1) fifty percent (50%) of the unpaid balance; or (2) $400.00), court costs and interest at a rate of 18% per year, calculated daily, beginning from the last date of service or the last payment date.

X____. ________________.

Printed Name Signature DATE

Please check all that apply to you or your family's health history.

	You	Family		You	Family
Glaucoma			High Blood Pressure		
Diabetes			Thyroid Disorder		
Cataracts			Heart or Lung Disease		
Crossed Eyes			HIV / AIDS		
Blurred Vision			Headaches or Numbness		
Dry Eyes			Dizziness		
Macular Degeneration			Recent Change in General Health		
Mucous			Sinus Condition		
Double Vision			Serious dental or ear problems		
Temporary Loss of Vision			Lymph node enlargement / Tenderness		
Sensitivity to Bright Lights			MS, MD, TB, or Kidney Disease		
Seeing Spots or Flashing Lights			Pain around eyes		
Seeing halos around lights			Eye or Head injury		

Are you currently under the care of any medical specialist? ____
If yes, please explain. ____
____

List any allergies to medications
____
____
____
____
____
____
____
____

List all medications you are taking (include eye drops) dosage and how long you have been taking
____
____
____
____
____
____
____

List any operations and the year
____
____
____
____

What is the reason for today's visit?
____
____
____
____

How did you hear about Dr. McKenna?___________________________________

Previous Patient Y / N _______________

Please list your hobbies / activities. This will help us recommend the best vision correction options for your lifestyle.
____
____

Are you interested in learning about Lasik?_______
Do you currently wear contact lenses? _________
Are you interested in finding out more about contact lenses? _________