Today's date: _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Home Address: _____ City: _____ Zip: _____

Date of Birth: _____/_____/_____ Male / Female / Other

Marital Status: Single / Married / Divorced / Widowed Spouse's Name: _____

If Minor, Responsible Party: _____ Relationship: _____

Are you employed? Yes / No Employer: _____ Occupation: _____

Employer's address: _____ City: _____ Zip: _____

Email Address: _____

Home Phone #: _____-_____-_____ Cell Phone #: _____-_____-_____

Work Phone #: _____-_____-_____ Ext.:_____

Primary Insurance: _____ Subscriber: _____

Secondary Insurance: _____ Subscriber: _____

Name & Phone Number of nearest friend or relative other than spouse: _____

Phone #: _____-_____-_____

Weight: _____ Height: _____ Smoke? Yes / No

If you have any of the following conditions, PLEASE CIRCLE:

HEART PROBLEMS
-Heart attack
-Angina
-Arrhythmia/ Pacemaker
-Congestive heart failure
-High blood pressure
STROKE
BLEEDING DISORDER

LUNG PROBLEMS
-Asthma
-Emphysema
-Bronchitis
-COPD
-Asbestosis
-Pneumonia

HEARING PROBLEMS
KIDNEY PROBLEMS
DIABETES Type 1 / Type 2
Current A1C: _____
Family History of Diabetes
Family History of Glaucoma

Referred by: _____
Personal Physician: _____ Phone #: _____-_____-_____
List of prior eye surgeries: _____
Any diagnosed eye diseases: _____
Current Medications: _____
Drug Allergies: _____
Do you currently wear prescription glasses or contact lenses? _____

Patient's Lifetime Signature Authorization
I request that payment under the medical insurance program be made to Hertzog Eye Associates on any bills or services furnished to me by the Association during period from _____/_____/_____ until further notification by me in writing. I authorize any holder of medical information about me that is needed to determine payable benefits to release it to the Heath Care Financing Administration or insurance company.

Signature of Patient: _____ Date: _____/_____/_____