# Acquaintance Form

**PERSONAL INFO**

| Patient Name | DOB: | Home Phone #: |
|---|---|---|
| Email Address: | SSN: | Cell Phone #: |
| Address: | Sex: | Preferred Language |
| Apt: | Race: ❑ American Indian or Alaskan Native ❑ Native Hawaiian or other Pacific Islander ❑ Asian ❑ White / Caucasian ❑ Black / African American | |
| City-State-Zip | | |
| Drivers License: | Ethnicity: ❑ Hispanic / Latino ❑ Non-Hispanic / Latino | |
| Communications Preference: ❑ email ❑ Postal ❑ Telephone | Is Texting OK? ❑ Yes ❑ No | |

**MINOR**

IF PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION

| Responsible Adult | Address if different than above | Sex: ❑ Male ❑ Female |
|---|---|---|
| Relationship | City-State-Zip | Phone #: |

**INSURANCE**

| **PRIMARY INSURANCE CO:** | Policy Holder - if other than patient |
|---|---|
| Policy Number: | Relationship to patient: |
| Group Number: | Date of Birth: |
| **SECONDARY INSURANCE CO:** | Policy Holder - if other than patient |
| Policy Number: | Relationship to patient: |
| Group Number: | Date of Birth: |

**EYE HISTORY**

When was your last examination?

_____ No Problems
_____ Eye Pain
_____ Eyes Red
_____ Eyes Burn
_____ Eyes Water
_____ Discharge

What is the reason for your visit today?

_____ Cataracts
_____ Glaucoma
_____ Double Vision
_____ Floaters
_____ Dryness
_____ Decrease Vision
_____ Flashes of Light
_____ Loss Of Side Vision
_____ Halos (around lights)
_____ Macular Degeneration
_____ Lazy Eye (Amblyopia)
_____ Other

EYE INJURY/SURGERY: ______________________ EYE MEDICATIONS: ______________________

**HEALTH HISTORY**

_____ No Problems
_____ Diabetes
_____ Thyroid/Liver Problems
_____ Headaches
_____ Arthritis
_____ Mood
_____ Asthma
_____ Hypertension
_____ Allergies / Sinus
_____ Stroke
_____ Cholesterol
_____ COPD
_____ Heart Problems
_____ Cancer
_____ HIV Positive

Are You Pregnant? ❑ YES ❑ NO Do You Smoke?: ❑ YES ❑ NO # Packs per Day: ______________

Do you drink alcoholic beverages?: ❑ YES ❑ NO How Much?: ______________ How Often?: ______________
Primary Care Physician?: ______________________ Phone: ______________ Surgeries?: ______________
Medications?: ______________________________________ Allergies?: ______________

**FAMILY**

(CHECK THOSE THAT APPLY TO ANYONE IN YOUR FAMILY)

_______ Glaucoma
_______ Hypertension Diabetes
_______ Cataracts Eye Disease
_______ Cancer
_______ Blindness
_______ Other

**By signing, I understand that if my insurance company does not cover the these services, in full or in part, the balance becomes my responsibility. I authorize release of my medical records to process my insurance. I request that payment of authorized insurance benefits be made on my behalf to this office for any services furnished to me.**

______________________ ______________________ ______________

**Parent/Guardian** **Relationship** **Date**

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PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD