Name _____ DATE _____
Mailing Address _____ Insured's DOB_____
City, St, Zip_____ Name of Insured_____
Gender: Male_____Female_____ Insurance_____
Birthdate_____ Insured last 4 digits of SSI#_____

For your convenience and to make our communications with you more efficient regarding appointments, eyeglasses and contact lens orders, we can now contact you by the following methods. Please select your preferences:

___Text Msg Cell Phone#_____
___Email **Email Address**_____
___Phone Phone #_____

Race/Ethnicity: ___American Indian/Alaska Native ___Native Hawaiian/Other Pacific Islander
___Black or African American ___Hispanic ___Asian ___White

Primary Care Physician: _____
Reason for visit today: ___New Glasses ___New Contacts Other_____

Please check all of the following that apply to you:

Medical	Eye	Eye Surgery
___High Blood Pressure	___Lazy Eye	___Cataract Surgery
___Diabetes Type 1 or 2	___Eye Allergies	___Lazy Eye Surgery
___Thyroid Disease	___Cataracts	___LASIK
___Arthritis	___Glaucoma	___Macular Degeneration
___Retinal Detachment		

Surgeries:_____
Other Health History: _____
Please list **MEDICATIONS** you are taking (if you don't know the name, write the medical condition it is for.)
_____
_____
Allergies: _____**Medication Allergies:**_____
Do you have any **FAMILY HISTORY** of ___Macular Degeneration ___Glaucoma ___Blindness ___Retinal Detachment ____Other
Do you smoke? Y N Quit Do You use alcohol? Y N Quit Do you use drugs? Y N Quit
Are you Pregnant or Nursing? ___Yes ___No
Do you want to be dilated today? ___Yes ___No

Note: Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information given to us by your insurance company. Bingham Family Vision will gladly bill your insurance on your behalf. I understand that I am responsible for any balance my insurance does not pay. **PAYMENT DUE IN FULL AT TIME OF SERVICE**

Signature: _____ Date:
_____