

Welcome to the Office of Dr. Thomas and Associates

Name: _____ Birth Date: ____/____/____
 Home Address: _____ City: _____ Zip: _____
 Social Security No: _____ Home Phone: _____ Work: _____
 Last Medical Exam: ____/____/____ Last Eye Exam: ____/____/____ Sex: M ___ F ___ Age ____
 Insurance: _____ Occupation & Employer: _____
 Policy Holders' Name and SS#: _____

Welcome to Our Office

Family Information

Our office focus is on family care. Therefore, we like to keep family records together, please list family members that are part of your household. Remember that many children have the similar need for glasses, just like their parents. Additionally, because children are growing so fast, we recommend an annual eye exam by a doctor to ensure good learning at school.

Examined here before?

_____	Birthdate	<input type="checkbox"/> yes
_____	Birthdate	<input type="checkbox"/> yes
_____	Birthdate	<input type="checkbox"/> yes

Social History-

Please indicate hobbies and interests: Computers Hunting Fishing Music Public Speaking Golfing
 Do you drive? yes no
 Do you use tobacco products? yes no If yes, type/amount/how long: _____
 Do you drink alcohol? yes no If yes, type/amount/how long: _____
 Do you use illegal drugs? yes no If yes, type/amount/how long: _____
 Please indicate if you have been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis

Family History-

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following:

DISEASE/CONDITION	YES	NO		YES	NO
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease/Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

If YES, which relatives: _____

INSURANCE and PAYMENT POLICIES-

Our office provides a trained insurance manager to assist in filing your insurance. With your permission we keep your signature on file to process your claims.

Payment for services is needed at the time of your visit, unless prior arrangements have been made. Payment of half is due to order your custom glasses or contacts and the balance is due upon pick up. After ninety days in default of payment, you agree to pay the collection fees as permitted by state law.

YES _____ (Signature authorization for insurance & collections)