

O P T I C A L

Patient Info

Last Name	First Name
Address	City/ St/ Zip
Phone	Work Phone
Date of Birth	SSN
Occupation	Employer
Sex	Eye Color
Email	

Parent/ Guardian Info

Name	Relationship
Address	City/ St/ Zip
Phone	Alt Phone
D.O.B.	SSN

Vision Insurance Info

Ins Company	Plan
ID #	Group#
Auth# (if appl.)	Invoice # (if appl.)
Name of Subscriber	SSN of Subscriber (if appl.)

Medical Insurance Info

Ins Company	Plan
ID #	Group#
Name of Subscriber	Relationship to Insured SELF SPOUSE CHILD OTHER
DOB of Subscriber	Patient's Name

Medicare Patients: Please Read and sign the following

"I request that payment of authorized Medicare benefits be made to Dr. H.Ronald Hirsch for any services furnished to me by that physician. I authorize the release of any medical information about me to the Health Care Financing Administration and its agency to determine these benefits or the benefits payable for related services. I understand that I am financially responsible to the said physician for any balance not covered by my insurance carrier at the time of service. I understand that any delinquent payments as determined by this office are subject to collection and civil prosecution by magisterial decree."

Patient Signature _____ Date _____

Have you been a patient in this office before? Yes No

Have you been a patient in one of our other offices? Yes No

If yes, which office and how long ago? _____

If no, how did you hear about our office? _____

If by a friend, what is their name? _____

Do you currently wear eyeglasses? Yes No

Do you currently wear Contact Lenses? Yes No

If yes, please specify brand / type _____

Have you had eye surgery? _____ What kind: _____ Date: _____

Do you have any of the following conditions:		
	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Dry Eyes		
Diabetes		
Headaches		
Flashers		
High Blood Pressure		
Allergies		
Floater		
High Cholesterol		
Arthritis		
Other (list)		

Is there a family history of:		
	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Amblyopia/ Lazy Eye		
Diabetes		
Retinal Detachment		
Eye Diseases		
Other		

Do you use:			
	Yes	No	How Often
Cigarettes			
Tobacco			
Alcohol			
Caffeine			
Narcotics			

Date of Last Physical ___/___/___

Please list all medications that you take:

List any visual &/or eye conditions: _____

Date of occurrence (s): _____

I would like a copy of the office HIPPA privacy policy: <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient or Guardian Signature _____ Date _____

*** It is the patient's responsibility to know their insurance coverage / eligibility. If you have any questions or concerns please see the front desk BEFORE your exam. Any co-payments must be paid at the time of service. Thank You!

click the button to [to info@dalmooptical.com](mailto:info@dalmooptical.com)