

Patient Questionnaire

Mr. Mrs. Ms. Marital Status: S M D W Today's Date _____
Name: _____ Soc. Sec. # : _____
First Middle Last
If Minor Parents Soc. Sec. # _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Employer: _____
Phone: Home _____ Phone: Business _____
Name of Spouse or Parent (if minor): _____ Cell Phone: _____
 Spouse Parent Employment: _____ Spouse Parent Work Phone: _____

Insurance Information

Name of Company: _____ ID#: _____
Policy Holder's Name: _____ Group#: _____
Policy Holder's Date of Birth: _____ Medicaid#: _____
Policy Holder's Place of Employment: _____ Medicare#: _____

Fee Policy

Exam fee is due on date of examination. A deposit is required for glasses or contact lenses to be ordered. The balance is due when dispensed.

Method of Payment

Cash Check Credit Card

I agree to pay for all services and materials provided by the office of Drs. Wolf & Hatfield.

Signature _____

Medical History

Name of Medical Doctor: _____ Last Medical Exam: _____

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List all major injuries, surgeries and /or hospitalizations you have had: _____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury.

Are you interested in Lasik? no yes

Are you pregnant and/or nursing? no yes Last Eye Exam: _____

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Family History

Are you interested in laser vision correction? no yes

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

DISEASE/CONDITION	NO	YES	?	DISEASE/CONDITION	NO	YES	?
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please turn this form over and complete side two

