

Name \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_ - \_\_\_ - \_\_\_\_.

Who is responsible for charges on this account? \_\_\_\_\_ Marital status: M S D W

Phone number: ( ) - Email: @

Mailing address: \_\_\_\_\_, city: \_\_\_\_\_, state: \_\_\_\_\_ zip: \_\_\_\_\_

r4v Date of last **EYE** exam \_\_\_/\_\_\_/\_\_\_ Last **MEDICAL** exam: \_\_\_/\_\_\_ (mo/yr) Medical Dr. \_\_\_\_\_

cc Briefly, what brings you in today? \_\_\_\_\_.

hpi **EYES** (poor vision, eye pain, tearing, redness, etc...) \_\_\_\_\_

pt hx Have you had any **eye surgeries**? \_\_\_\_\_

Do you have any **allergies** to medications? Yes (to what?) \_\_\_\_\_ No

Has your mother, father, grandparent or sibling had any of these diseases? (circle all that apply)  
Blindness, Glaucoma, Diabetes, Hypertension, Thyroid disease, Arthritis, Corneal dystrophy, other heritable disease: \_\_\_\_\_

Does your vision limit any activities of daily living (driving, reading, sports, work, etc)? Yes No

Do you drink alcohol? Yes No \_\_\_\_\_ Do you smoke? Yes No Do you use illegal drugs? Yes No

**MEDICATIONS:** list those you currently take, (Rx and over the counter) **and what condition you take them for:**

\_\_\_\_\_  
\_\_\_\_\_

Any other major illnesses or injuries? \_\_\_\_\_

ros  
What do you use for sun protection? \_\_\_\_\_

**IT IS OUR POLICY TO RECEIVE PAYMENT AT THE TIME OF SERVICE** unless you are covered by an insurance carrier or Medicare. You are then expected to pay for the amount not covered by your insurance.

I hereby authorize Dr. Bergstrom and Dr. Neal to furnish my insurance company with information concerning my care and services rendered and assign all benefits to them. I also understand any balance not covered by my insurance is due and payable by me.

Signature \_\_\_\_\_ Date / /

**ACKNOWLEDGEMENT OF RECEIPT (OR REVIEW) OF NOTICE OF PRIVACY PRACTICES:**

I acknowledge that I reviewed a copy of Dr. Bergstrom and Dr. Neal's Notice of Privacy Practices.

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date / /