WELCOME TO THE OFFICE

In order to help us render the proper optometric services to you, please be kind enough to answer the following questions. Many things have a direct bearing on the health of your eyes. Information you give us is strictly confidential, and will not be released to anyone without your written permission. Thank you for your cooperation.

Name________________________ Sex______ Age______ Birthdate______________

Residence Address ____

Employed by ______________________ Occupation ____________________

Business Address____

Home Phone #______________________ Work Phone # __________________

Spouse, Parent or Guardian ____________________________________

Whom may we thank for referring you to our office: Name ______________________

Address ____

General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Family Physician______________________ Drug Store __________________

Please list all medication you are currently taking, including non-prescription drugs. Medication: __________

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For what purpose:____

Do you have or have you had any of the following? (Indicate with check mark)

☐ Circulatory problems ☐ Asthma or hay fever ☐ Nervous problems ☐ Blood pressure
☐ Heart problems ☐ Malignancies ☐ Arthritis ☐ Diabetes
☐ Epilepsy ☐ Pregnant ☐ Stroke ☐ Ulcer
☐ Sinus ☐ Allergies

Approximate date of your last eye examination______________ Doctor ______________

Have you worn glases before?__________ How long? ______________________

Have you worn contact lenses?__________ Are you interested in contact lenses? ______________

Have you or any family members been treated for? (Indicate with check mark)

(1) Cataracts__________ (2) Glaucoma__________ (3) Eye muscle problems__________

Have you ever had any major eye disease?__________ If yes please explain:______________________

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Have you ever had any severe injuries to your eyes?__________ If yes please explain: ______________

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It is customary to pay for services when rendered. Cash, check and credit cards are accepted. If glasses or contact lenses are prescribed patient will pay a deposit upon initial exam and balance when prescription(s) are dispensed. Patient having valid insurance plans must make arrangements to have the correct form and pay the difference on the account. Should you have any questions regarding our office policy, please ask us so that any misunderstanding is avoided.

Please complete the following:

Type of Insurance ______________________ Supplemental Insurance______________________

SS # of patient ______________________ SS # of insured ______________________

Name of insured ____

I hereby authorize Drs. Murray, Murray & Groves to furnish information to the insurance company upon their request, and payment made directly to the doctors office.

Signature____

Thank you for allowing us the opportunity of caring for your eyes and vision. Your trust and confidence in us is greatly appreciated.

Drs. Murray, Murray and Groves