

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____

home phone# (____)_____ work phone : _____

sex (circle) M F occupation _____ inst _____

Insured by (ex. Name of employer) _____

Last Eye Exam _____ presently w _____

family physician: _____

Occupation : _____

primary health insurance: _____

who may we thank for referring you to us? _____

PATIENT MEDICAL HISTORY

Are you currently being treated for any health problem? (Y/N) __

High Blood Pressure? (Y/I Y/N) _____ Diabetes? (Y/N) _____

Is there any family history of eye disease (specify)? _____

Do you wear contact lenses Y/N if "Yes", what type? _____

Are you currently being treated for any health problem? (Y/N) __

Are you currently being treated for any health problem? (Y/N) __

Are you currently being treated for any health problem? (Y/N) __

Are you interested in laser vision correction (Lasik surgery)? _____

Please list any allergies to medication you may have: _____

Briefly state the reason for today's visit: _____

PATIENT CONSENT FORM

I authorize the release of my medical or other information neces
I also request payment of benefits be made either to myself or to
assignments for services supplied.

I acknowledge that I received a copy of Dr. Ira Bourne's notice of

Patient name : _____

signature: _____ Date _____

PARK SQUARE VISION

DR. IRA BOURNE

_____ SSN: _____

(____) _____

Insurance company _____

insurance # _____

earing(circle) Glasses contacts

Vision insurance: _____ policy # _____

Other (specify)? _____

nary to process this claim.

) the physicians or supplier who accepts assignments for se

privacy practices.

!:: _____
