DR. DAVID JAMES & DR. CALLIE ENYART, OPTOMETRISTS

OREGON (608) 835-3579 MONONA (608) 223-0202

Please complete this questionnaire prior to your appointment and return it to the front office staff when you arrive.

- **Please bring your Vision Insurance and Health Insurance ID cards to your appointment.**
- Contact Lens Patients - Wear your contact lenses to your appointment. Bring your glasses and contact lens prescription or boxes.
- Copays will be collected at time of service.

We ***accept*** the following forms of payment: *Cash, Check, Visa, & Master card.*

If you are unable to keep your appointment, please call at least 24 hours prior to your scheduled appointment.

Patient Information (PLEASE PRINT)

Patient Name: ______________________________ DOB: ____/____/______
Last First MI

SSN: ______________ (*Circle appropriate*) Male Female Home phone: ______________

Address: ______________________________ Cell phone: ______________

City: ______________ State: _____ Zip: __________ E-mail: ______________

(*Circle appropriate*) Minor Single Married

Patient or parent/guardian's employer: ______________ Work phone: ______________

Occupation: ______________________________

Emergency Contact: ______________________ Phone: ______________

Whom may we thank for referring you? ______________

Vision Insurance Information

Name of insured/responsible party: ______________________________
Last First MI

DOB: ____/____/______ SSN: ______________

Employer: ______________________ Work phone: ______________

Insurance company: ______________________ Group or Plan#: ______________

Insurance address: ______________________ City: ______________ State: _____ Zip: ________

Is person a current patient? Yes or No

Do you have additional insurance? Yes or No *If yes complete the following*:

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Name of insured/responsible party: ______________________________
Last First MI

DOB: ____/____/______ SSN: ______________

Employer: ______________________ Work phone: ______________

Insurance company: ______________________ Group or Plan#: ______________

Insurance address: ______________________ City: ______________ State: _____ Zip: ________

Health History

Fill out this information to the best of your ability. Providing incorrect information can be *dangerous* to your health. Please inform our office when there are any changes in the medical information you provide below.

Do you wear **glasses?** Yes/No **contact lenses?** Yes/No

Have you ever had any of the following eye conditions? (Circle Yes or No)

Sandy or Gritty	Yes/No	Glaucoma	Yes/No	Loss of Peripheral Vision	Yes/No
Itchy	Yes/No	Loss of Vision	Yes/No	Double Vision	Yes/No
Burning	Yes/No	Blurred Vision	Yes/No	Dryness	Yes/No
Foreign Body Sensation	Yes/No	Fluctuating Vision	Yes/No	Mucous Discharge	Yes/No
Excess Tearing	Yes/No	Distorted Vision	Yes/No	Redness	Yes/No
Glare/Light Sensitivity	Yes/No	Tired Eyes	Yes/No	Lazy/Crossed Eye	Yes/No
Pain or Soreness	Yes/No	Drooping Eyelid	Yes/No	Retinal Detachment	Yes/No
Infection	Yes/No	Cataracts	Yes/No	Macular Degeneration	Yes/No
Flashes/Floaters	Yes/No	Eye Surgeries	Yes/No	Eye Injury	Yes/No

Medical Information

How is your general health? *(Circle appropriate)* Excellent Good Fair Poor

Medications (include Non-Prescription):____

____

Allergies to medicine? Which?______________________ Reactions?______________________

Do you have any health issues with any of these systems? (Circle Yes or No)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary(skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Mental	Yes/No		

Explain: ______________________________

Family History

High Blood Pressure	Yes/No	Relation: ____________	Macular degeneration	Yes/No	Relation: ____________
Diabetes	Yes/No	Relation: ____________	Retinal Detachment	Yes/No	Relation: ____________
Glaucoma	Yes/No	Relation: ____________	Cataracts	Yes/No	Relation: ____________

Authorization & Release

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor and any **denied** services are my responsibility.

X ____ date: ______________
SIGNATURE OF PATIENT/PARENT/OR GUARDIAN