WELCOME TO OUR OFFICE
PHILIP R. MILL, O.D.
MICHAEL D. SUTTON, O.D.

Patient's Name _____ Circle One Male/Female Date _____

Address _____ City _____ Zip _____

Age _____ Date of Birth _____ Social Security # _____

Home Phone _____ Page / Cell Phone _____

Employer _____ Occupation _____ Work Phone _____

Email _____

Spouse's Name _____ Date of last eye exam? _____

Children's Names, Ages, and date of last exam? _____

_____

_____

Whom may we Thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance Information

Name _____ DOB _____ SSN _____
(If different from above)
Insurance Name _____ Policy # _____

If Patient is a Minor – and in the event I am unable to accompany my Child, I authorized _____ or _____ to accompany him/her to the Doctor's Office and to receive information concerning his/her health.

Signature of Patient or Guardian _____

*****PLEASE TURN PAGE*****

_____
Doctor's Initials

PATIENT HEALTH INFORMATION

Date of Last Eye Exam _____ Where? _____ Dilated? _____

Do you wear Glasses? Y/N Do you wear Contact Lenses? Y/N **If yes, for what Purpose?**

Near (Reading) Y/N **Intermediate (Computer)** Y/N **Distance (Driving)?** Y/N

Have you experienced or been diagnosed with any of the following? ***PLEASE CIRCLE Y OR NO***

Blurred Vision	Y/N	Glaucoma	Y/N
Circle: One / Both Distance / Near		Cataracts	Y/N
Frequent Headaches	Y/N	High Blood Pressure	Y/N
Dry Eyes	Y/N	Diabetes	Y/N
Burning In or Around Eyes	Y/N	Type/Date_____	
Seeing Black, Floating Spots	Y/N	Other Eye Conditions	Y/N
Seeing Flashes of Lights	Y/N	Explain_____	
Cloud or Curtain cover part of Vision	Y/N	Eye Surgery/Injury	Y/N

Have you had any operations? Y/N Type: _____ When? _____
Do you use Cigarettes/Tobacco? _____ Alcohol? _____ Other Substance(s)? _____

Allergies? _____
_____

Current Medication	**Reason (HBP, Diabetes, Etc.)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HEALTH HISTORY

High Blood Pressure Y/N Relation _____ Diabetes Y/N Relation _____
Glaucoma Y/N Relation _____ Macular Degeneration Y/N Relation _____
Cataracts Y/N Relation _____ Retinal Detachment Y/N Relation _____
Other eye Condition(s) Y/N What Kind? _____ Relation _____

INITIAL AND DATE – ONLY ONCE PER YEAR

I have reviewed this form and the above information accurately reflects my current medical and eye health history.

Patient Initials _____ Date _____ Patient Initials _____ Date _____
Patient Initials _____ Date _____ Patient Initials _____ Date _____