

Scott L. Nehring, O.D., P.C.
Welcome Back To Our Office

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Please circle all that apply: Mr. Miss Mrs. Ms. Male Female Single Married Student Employed

First Name Middle Initial Last Name

Street Address/Mailing Address City Zip

Social Security Number Date of Birth Home Phone Work Phone

Email Address Person Responsible for Account (Must sign at bottom)

How were you referred to our office? _____

PRIMARY INSURANCE INFORMATION

Name/Address

Policy Holder's Name Policy Holder's ID Number

Patient Relationship to Insured

Self Spouse Child Other

Group Number Insured's Date of Birth

SECONDARY INSURANCE INFORMATION

Name/Address

Policy Holder's Name Policy Holder's ID Number

Patient Relationship to Insured

Self Spouse Child Other

Group Number Policy Holder's Date of Birth

PLEASE READ CAREFULLY:

We ask that the patients portion is paid at the time services are rendered unless other arrangements are made in advance, since most insurance policies only pay a portion of your total charges. Please understand that financial responsibility for your account is yours, not your insurance company's. Payment from my insurance is to be paid directly to Scott L. Nehring, O.D., P.C.. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services rendered.

Signature of Responsible Party

Date

PATIENT HISTORY AND INFORMATION: Please answer the questions as they apply to you.

What is the main reason for today's exam? _____ Current Occupation _____
Employer _____ Do you use a computer? Yes No How many hours/day: _____

Spectacle Lens History:

Do you currently wear glasses? Yes No Wearing Schedule: FullTime PartTime Distance Close
Glasses Owned:
 SingleVision Bifocals Trifocals Backup Safety Sports Progressive

Contact Lens History:

Do you currently wear contact lenses? Yes No Type/brand of contact lenses _____
Are you interested in trying contact lenses at this time? Yes No

Refractive Surgery:

Are you interested in LASIK or other refractive surgery options? Yes No

Social History:

Do you use nutritional supplements? Yes No Do you exercise regularly? Yes No
Do you smoke? Yes No
Do you drink alcohol? Yes No
Hobbies/ Interests : _____

Medical History: Please mark all that apply

EYE HISTORY:

Burning	<input type="radio"/> Yes <input type="radio"/> No	Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No
Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No
Redness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No	Floater or Spots	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
				Glaucoma	<input type="radio"/> Yes <input type="radio"/> No

General Health Condition: Please mark the conditions you are currently being treated for:

Fever	<input type="radio"/> Yes <input type="radio"/> No	Ears,Nose,Throat	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Heart	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No
Psychiatric	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid	<input type="radio"/> Yes <input type="radio"/> No
Kidney	<input type="radio"/> Yes <input type="radio"/> No	Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Allergies	<input type="radio"/> Yes <input type="radio"/> No
Pregnancy	<input type="radio"/> Yes <input type="radio"/> No	Muscles/Bones/Joints	<input type="radio"/> Yes <input type="radio"/> No	Neurological (MS)	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Skin Disorder (Eczema)	<input type="radio"/> Yes <input type="radio"/> No	Other (please specify)	_____

Current Medications: _____

Medications that cause reactions or sensitivities _____

Past Eye Surgeries: _____

Who is your Primary Care Physician: _____

FAMILY HISTORY

Lazy Eye	<input type="radio"/> Yes <input type="radio"/> No	Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Others (please specify)	_____				