PATIENT INFORMATION SHEET

Name: _____ D.O.B.: _____ SSN: _____

Male / Female / Non-binary / Prefer not to say Single / Married / Divorced / Widowed / Other

Address: _____ Apt: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Name of Employer or School: _____

Reason for today's visit: _____

Primary care physician: _____ Phone: _____

Medical Insurance: _____ Member ID#: _____

Vision Insurance: _____ Member ID#: _____

If the patient is a minor or the primary insured is different than the patient, please complete the following below:

Primary insured's name: _____ D.O.B: _____

Primary insured's address: _____ Apt: _____

City: _____ State: _____ Zip code: _____

Primary insured's phone numbers: Cell: _____ Home: _____ Work: _____

Primary insured's employer: _____ Relationship to patient: _____

Please circle an S if you have, or an F if any family member (parents, grandparents, siblings) has/had, any of the following:

High Blood Pressure	S	F	Macular Degeneration	S	F	Double vision	S	F
Diabetes	S	F	Glaucoma	S	F	Lazy eye	S	F
Respiratory problems	S	F	Cataracts	S	F	Blindness	S	F
Thyroid problems	S	F	Eye surgery	S	F	Retinal Detachment	S	F
Heart problems	S	F	Loss of vision	S	F	Head / Eye injury	S	F

Allergies: _____

Medications: _____

I understand that I am personally responsible for payment for services rendered by Dr. Hathaway that are not covered by my insurance plan or if I am not eligible for such services at the time they are rendered.

I understand there is an addition fee for a contact lens fitting and follow-up, over and above the cost of a routine eye exam. This contact lens fitting may not be covered by my insurance plan.

Glasses or contact lenses not picked up within 90 days may be donated or returned. Co-payments or partial payments will not be refunded.

_____ _____ _____

Patient or Patient's Parent or Legal Guardian Relationship to Patient Date