Date:_____

WELCOME TO OUR OFFICE

E. CY BURKHART, OD • ADAM G. REISING, OD

NAME_____

ADDRESS_____**CITY**_____**ZIP**_____

PHONE # HOME_____**WORK**_____

Email_____

SS#_____**Referred by**_____

EMPLOYER_____

BIRTHDATE_____**PARENT (if minor)**_____

METHOD OF PAYMENT Cash/Check___ Credit Card___ Medicaid___ Medicare___

INSURANCE? Type, Company, Group # _____

FAMILY PHYSICIAN_____

CURRENT MEDICATIONS_____

_____

DRUG ALLERGIES_____

HEALTH HISTORY (check or circle all that may apply to you)

Allergies	Dry eye	Hay fever	Smoking
Arthritis	Eye disease	High blood pressure	Alcohol use
Asthma	Eye inflammation	Seeing double	High Cholesterol
Blurred vision	Eye injury	Seeing spots	Other_____
Cancer	Eye pain	Serious head injury	_____
Cataracts	Eye surgery	Sinus problems	_____
Diabetes	Frequent headaches	Stroke	_____
Dizziness	Glaucoma	Watery eyes	_____

FAMILY HISTORY

Blindness	Eye disease	High blood pressure	Turned eye
Cancer	Glaucoma	Lazy eye	Other_____
Diabetes	Heart disease	Macular degeneration	_____

If you have insurance, please give the form or card to the receptionist. We will help you file the claim and your insurance company may (or may not) make payment to us. The responsibility for full payment of the account is yours.