Today's Vision Oak Cliff

We are delighted to have you as a patient and appreciate the confidence you placed in us for your eye care needs.

Please take a moment to review/complete the following patient information (please print):

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

Patient's First Name _____ MI _____ Last Name _____

Patient's Date of Birth _____ Social Security Number _____

Street Address _____

City _____ State _____ Zip Code _____

( ) _____
Home Phone

***Required to receive appointment reminders and eyewear pick-up notifications by text and/or email:**

( ) _____
Cell Phone*

_____
Email Address*

Patient Medical History (Please check Yes or No):

Diabetes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Thyroid Condition	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No

Other _____

Patient Ocular History (Please check Yes or No):

Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Trauma	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No

If Yes, which eye: ☐ Right ☐ Left

Explain: _____

Vision Insurance Information:

_____
Name of Vision Insurance Company

_____
Primary's Insurance ID or Social Security Number

_____ _____
Primary Insured First Name Primary Insured Last Name

_____
Primary Insured Date of Birth

Patient's Relationship to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Status: ☐ Single ☐ Married ☐ Other

Patient's Work Status:
☐ Employed ☐ Part-Time Student ☐ Full-Time Student
☐ Not Employed ☐ Retired

Medical Insurance Information:

_____
Name of Medical Insurance Company

_____
Primary's Insurance ID or Social Security Number

_____ _____
Primary Insured First Name Primary Insured Last Name

_____
Primary Insured Date of Birth

Patient's Relationship to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Status: ☐ Single ☐ Married ☐ Other

Patient's Work Status:
☐ Employed ☐ Part-Time Student ☐ Full-Time Student

My signature below allows payment of insurance benefits be made to Today's Vision Oak Cliff on my behalf for all services/materials furnished. Even though I have insurance coverage, it is NOT a guarantee of payment for services/materials and understand that I am financially responsible for all deductibles, services, and other charges not covered by my insurance.
Also, my signature below acknowledges that I may request a copy of the **Notice of Privacy of Today's Vision Oak Cliff.**

_____ _____
Signature (If under 18, Parent/Legal Guardian Signature) **Date**