Hansen Vision Care
Dr. Dwight Hansen OD

Patient Registration & Medical History

Patients Name: _____ **Today's Date: _____/_____/_____**

Address: _____ **Home Phone: _____**

City_____ State_____ Zip_____ **Cell Phone: _____**

Birth date: _____/_____/_____ **Work Phone: _____**

Sex: M F Married: Yes No **Email: _____**

Social Security #_____ **Employer: _____**

Parent or Legal Guardian_____ **Parent phone number_____**

Parents date of birth_____/_____/_____ **Parents Social Security #_____**

Emergency Contact: _____ **Emergency contact Phone #: _____**

Insurance Information: ***Do you have health insurance?*** Yes No ***Do you have vision insurance*****?** Yes No

Name of insurance company_____ Policy Holder_____

Relationship to Policy Holder_____ Policy Holders Social Security No _____-_____-_____

Policy Holder's Birth date_____/_____/_____ Policy Holder Phone Number (_____)-_____-_____

General Health

Have you ever had, or do you currently have…..

- ☐ Arthritis
- ☐ Allergies
- ☐ Diabetes
- ☐ Cancer
- ☐ Headaches
- ☐ Drug allergies
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Respiratory Disease
- ☐ Eye Disease
- ☐ Eye Surgery
- ☐ Delivered a baby in the past 6 months
- ☐ Sensitive to Light
- ☐ None of the above

Have you ever had any of the following conditions involving your eyes*?*

- ☐ Eye injury
- ☐ Floaters or spots
- ☐ Double vision
- ☐ Poor distance vision
- ☐ Poor near vision
- ☐ Eye strain
- ☐ Severe pain in the eye
- ☐ Eye burn or itch
- ☐ None of the above

Current Medications:

I assume all financial responsibility for this patients account for any amounts due, regardless of insurance coverage.

Payment for all medical services is the responsibility of the patient and is expected at the time of service unless other arrangements are made. I understand the entire account balance will be considered delinquent upon failure to pay for these services and therefore may be turned over to a collection agency.

I understand cancellations on eyeglasses are not permitted, as all eyeglasses are custom crafted for each patient with their unique prescription. I certify that I understand that all sales of visual aids which include contact lenses, eyeglasses and all low vision tools are final.

I certify that my responses on this form are accurate to the best of my knowledge.

Patient Signature_____ Date_____

Hansen Vision Care
Dr. Dwight Hansen OD

Please list all medications that you are currently taking: _____

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