Patient Information Sheet	Dr. So, Optometrist	Date:
Last Name:	First Name:	Middle Name
Guardian Last Name	First Name:	Middle Name
Address:	City	Zip:
Home Phone:	Cell Phone:	Work Phone:
Date Of Birth:	Social Security #	Cash Paying? Y N
Eye Insurance Company Name:	Group #	Subscriber ID #
Medical Insurance Company Name:	Group #	Subscriber ID #
Medical Insurance Type (please circle): PPO HMO	**Email Address:**	
How do you like us to contact you? (Please circle)	Email Phone	Other
How do you hear about us? (Please circle)	Walk-in Insurance List Advertisement (which one?)	
	Internet Previous Patient Referred (by whom?)	

Do you want to have any of the following additional tests performed today? Please circle your choice.

Dilation.	A dilation examination that involves expanding the pupil size for a complete evaluation of the interior of your eyes is highly recommended.	Yes No ($35 for all non-insurance patients)
Visual Field	A visual field exam that evaluates the integrity of the optic nerve pathway and diagnoses glaucoma & certain brain lesions is highly recommended.	Yes No ($35 for all non-insurance patients)

Why are you here today (Reason For Visit)?

Allergies to Medications	Conditions treated by medications	Medications being taken:
Previous Eye surgeries/Injuries:		

Privacy Practices Acknowledgement

I acknowledge that I have read/received a copy of Dr. Jimmy K. So, OD's Notice of Privacy Practice.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

(Guardian's signature if patient is <18yo)