Scott D. Burnop, O.D.

Patient Information

Today's Date: ___________________

Last Name: _______________________ First: ______________ Middle: ______________ Date of Birth: _____________

Mailing Address: _______________________________ City: _____________ State: ______ Zip: _____________

Home Phone: ________________ Day: ________________ Cell: ________________ Texting Allowed: __Yes __No

E-Mail: ____ Place of Employment: ___________________________

SS#: _____________________ Race _______________ Marital Status: ________________

Ethnicity: ____ Hawaiian/Pacific Islander ____ Hispanic/Latino ____ Not Hispanic or Latino

Insured/Responsible Party Information: Must be completed if under eighteen years of age OR if different from above.

Name: _______________________________ Date of Birth: _____________SS#: _____________________

Mailing address: ____ Phone: _____________________

Relationship to patient: _________________________

Do you or anyone in your immediate family have any of the following conditions?

____ Diabetes ____ Hypertension ____ Heart problems ____ Cancer ____ Breathing Problems
____ kidney problems ____ Thyroid ____ HIV ____ Glaucoma ____ Cataracts
____ Blindness ____ Lazy eye ____ Macular degeneration

If yes to any of the above, please explain ____

Are you experiencing any of the following?

____ frequent headaches ____ Poor distant vision ____ Poor near vision ____ Eye strain
____ Burning ____ Itching ____ Light sensitivity ____ Double vision
____ Flashes/floaters/spots Explain: ____

Do you currently wear?
____ Glasses ____ Contact lens

Past ocular history:
____ Eye surgery ____ Eye infection

Lifestyle choices: ____ Smoking ____ Drug/Alcohol use

List current medications: ____

____

Drug allergies: ____ Date of last eye exam: ____________________

I the undersigned, certify and assign to Royal Oak Eye Care all insurance benefits. I understand that I am financially responsible for all charges not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for any and all collection methods. I also acknowledge that I have had an opportunity to receive a copy of the Privacy Practices and Policies of this practice.

Signature: ____ **Date:** ________________