



Barry A. Wagner, O.D.  
Mark R. Sawusch, M.D

## Welcome to Our Office

**So that we can help you best, please fill out legibly and completely. Thank You!**

Name \_\_\_\_\_  
 Home address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
 Work phone \_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
 Cell phone \_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
 E-mail address \_\_\_\_\_

Today's date \_\_\_\_\_ Date of last eye exam \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Sex: M F  
 Social security number \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Emergency contact name \_\_\_\_\_  
 Emergency contact phone \_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name of Family Members at Home	Relationship	Age	Current Patient of Ours?	
			Y	N
			Y	N
			Y	N
			Y	N

Vision Insurance \_\_\_\_\_ How will you settle your account today?  
 Check       Cash       Credit Card

I authorize the release of payment for medical benefits to my Doctor of Optometry. I understand that I may have insurance co-payments and overages, and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Personal Medical History			
Do you smoke?	Y	N	Do you drink alcohol? Y N
Allergies	Y	N	Eye Disease Y N
Asthma	Y	N	Eye Surgery Y N
Arthritis	Y	N	Eye Injury Y N
Cancer	Y	N	Heart Disease Y N
Diabetes	Y	N	High Blood Pressure Y N
<b>Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)</b>			
Are you allergic to any medications? Y N (If yes, please list)			

Family Medical History		
Blindness or Visual Impairment	Y N	Unsure
Cataracts	Y N	Unsure
Diabetes	Y N	Unsure
Glaucoma	Y N	Unsure
High Blood Pressure	Y N	Unsure
Macular Degeneration	Y N	Unsure
Other eye disease (please specify) _____		