



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
Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)				
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)			
