

Lora L. Durst, O.D., L.L.C.
Eyecare and Contact Lenses

Welcome Back to Our Office!

Date: _____

LAST NAME	FIRST NAME, M.I.	SOCIAL SECURITY #	DATE OF BIRTH
MAILING ADDRESS	CITY	STATE AND ZIP CODE	E-MAIL ADDRESS
EMPLOYER	TYPE OF WORK	WORK/CELL PHONE #	HOME TELEPHONE #

List any medications you are **ALLERGIC** to: _____

Current Medications: _____

List medical conditions for which you are being treated: _____

When was your last complete **physical** exam? _____

Are you interested in contact lenses today? _____

	Yes	No
Blur at distance		
Blur at near		
Seeing double		
Seeing flashing lights		
Eyes burn, itch, or tear		
Headaches		

<p><u>Constitutional</u> ___ None <input type="checkbox"/> Developmental disability <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma</p>	<p><u>Allergic / Immunologic</u> ___ None <input type="checkbox"/> Drug allergy <input type="checkbox"/> Environmental allergy <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus</p>	<p><u>Cardiovascular</u> ___ None <input type="checkbox"/> Heart disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular disease</p>	<p><u>Endocrine</u> ___ None <input type="checkbox"/> Non-insulin depend. diabetes <input type="checkbox"/> Insulin depend. Diabetes <input type="checkbox"/> Thyroid dysfunction <input type="checkbox"/> Hormonal dysfunction</p>
<p><u>Genitourinary</u> ___ None <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Kidney ailments <input type="checkbox"/> STD-herpes, Chlamydia, HIV</p>	<p><u>Ears, Nose, Mouth, & Throat</u> ___ None <input type="checkbox"/> Upper respiratory tract infection</p>	<p><u>Integumentary (skin):</u> ___ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis</p>	<p><u>Blood / Lymphatic</u> ___ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia</p>
<p><u>Neurological</u> ___ None <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Epilepsy</p>	<p><u>Respiratory</u> ___ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema</p>	<p><u>Psychiatric</u> ___ None <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Panic Disorder</p>	<p><u>Musculoskeletal</u> ___ None <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Osteoarthritis</p>
<p><u>Gastrointestinal</u> ___ None <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Digestive</p>	<p><u>Insurance Information</u> ___ None Insurance Provider: _____ Name on Policy: _____</p>		

I hereby authorize any necessary medical treatment by Lora L. Durst, O.D., and agree to be responsible for my bill and any necessary collection fees made necessary to collect payment of services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize the office of Lora L. Durst, O.D. to release or obtain any required medical information from my attending physicians or any medical facility.

Patient's signature _____ Date _____

THERE ARE NO REFUNDS GIVEN FOR PROFESSIONAL SERVICES