Lora L. Durst, O.D., L.L.C.

Eyecare and Contact Lenses

Welcome to Our Office!

LAST NAME	FIRST NAME, M.I.	WHAT DO YOU PREFERED TO BE CALLED?	DATE
MAILING ADDRESS	CITY	STATE AND ZIP CODE	E-MAIL ADDRESS
EMPLOYER	TYPE OF WORK	DATE OF BIRTH	SOCIAL SECURITY #
PARENT NAME, if minor	SPOUSE NAME	HOME TELEPHONE #	WORK/CELL PHONE #

GENERAL HEALTH				EYE HISTORY				CURRENTVISUALPROBLEMS		
	Yes	No	In Family		Yes	No	In Family		Yes	No
Diabetes				**Glaucoma**				**Blur at distance**		
High Blood Pressure				**Cataract**				**Blur at near**		
Heart Problems				**Eye Injury**				**Seeing double**		
Arthritis				**Macular Degeneration**				**Seeing flashing lights**		
Thyroid Problems				**Eye Surgery**				**Eyes burn, itch, or tear**		
Smoke Cigarettes				**Eye Diseases**				**Headaches**		

List all medications which you are **ALLERGIC** to:____________________

Current Medications:____________________

List medical conditions for which you are being treated:____________________

Your primary care physician:____________________ When was your last complete **physical** exam?__________

Have you ever worn contact lenses? __________ Type? ____________________

Are you interested in contact lenses today?____________________

When was your last **eye** exam?__________ Who has your previous records?____________________

INSURANCE CARRIER Insurance Provider:____________________Policy Holder:____________________

REFERRAL INFORMATION How did you learn about our office (please circle the sources that apply)
Relative Friend Yellow Pages Website Doctor Referral Location Insurance Other:__________

Whom may we thank for referring you to our office?____________________

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