WELCOME TO DR. STEPHEN HYLE'S OFFICE

Personal Information

Patient's Name_____ Date of Birth_____

Social Security #_____ Male Female

Please circle one: Minor Single Married

Address_____

City_____State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Occupation_____

Responsible Party

Please complete this section if the person responsible for the account is somebody other than the patient OR the patient is a minor.

Name_____ Relationship to Patient_____

Date of Birth_____ Social Security #_____

Address_____

City_____State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Occupation_____

Insurance Information

Primary Insurance

Name of Insured_____ Relationship to Patient_____

Insured's Birthdate_____ Social Security #_____

Employer_____ Occupation_____

Insurance Company_____

ID#_____ Group#_____

Insurance Company's Address_____

Insurance Company's Telephone #_____

Medical Information

Primary reason for visit today is_____

Do you currently wear glasses Yes No
Do you currently wear contact lenses? Yes No
If no, are you interested in contact lenses? Yes No

Are You Currently Experiencing Any of the Following?
Dry Eyes Yes No
Vision Problems Yes No

Individuals/Family History:

Are you currently taking any medications? Yes No
If yes, please list_____

Are you allergic to any medications? Yes No
If yes, please list_____

Do you have high blood pressure? Yes No

Do you or a family member have glaucoma? Yes No
If yes, who?_____

Do you or a family member have cataracts? Yes No
If yes, who?_____

Do you or a family member have diabetes? Yes No
If yes, who?_____

Do you or a family member have macular degeneration? Yes No
If yes, who?_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my dependent to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that the doctor will bill my medical and/or vision insurance on my behalf or my dependents and I agree to be responsible for any amounts not paid by my insurance company for services rendered.

Signature_____ Date_____