Williamsburg Eye Care **Patient Information**

Last Name	**First**	**Middle Initial**	**SS#**

Address	**City**	**State**	**Zip**

Date of Birth	**Gender** M F	**Email**	**Communication Preference** Email Telephone

Home Phone	**Day Phone**	**Cell Phone**	**Receive Text Message** Yes No

Employed/Unemployed	**Marital Status**	**Preferred Language**
Full-Time/Part-Time	S M D W	English/Other________________________

Medical Insurance	**Policy Holder/Guarantor**	**SS#**	**DOB**
Policy Holder's Address if Different			

Vision Insurance	**Policy Holder/Guarantor**	**SS#**	**DOB**
Policy Holder's Address if Different			

Insurance Related Policies

Refraction: Some plans do not cover refraction – this is the part of the exam that determines your prescription for eyeglasses. The fee for refraction is $35.00 payable at the time-of-visit and will be due by you if your particular plan does not cover this service.

Contact Lenses: Most insurance plans do not cover testing related to evaluating, fitting or prescribing contact lenses. In these cases, any services relating to contact lenses will be due from you at the time-of-visit.

Patient /Guarantor Agreement

On my behalf and on behalf of my spouse and minor children including stepchildren, I authorize treatment by Dr. Pamela Lundberg and /or Dr. Richard K. Lodwick and the release of any information necessary to expedite insurance claims. I further authorize Dr. Lundberg and/or Dr. Lodwick to release or obtain any required medical information from my attending physicians or any medical facility. I accept responsibility and guarantee payment for all services rendered to my family and me, including a service fee of $10 for services not paid for at time of visit, a return check fee of $25.00 and fees up to 35% if the unpaid balance is submitted to a collection agency.

Signature____ Date______________________

Williamsburg Eye Care **Medical History**

Last Name	**First**	**Middle Initial**	**DoB**

Personal and Family Medical History		**Self Yes**	**Self No**	**Family Yes**	**Medications**
Constitutional (Developmental, Autism, Fever, Weight Loss)		☐	☐	**NA**	
Ear/Nose/Throat (Allergies, Sinus)		☐	☐	☐	
Neurological (Migraines, Seizures, MS)		☐	☐	☐	
Psychiatric (Depression, Anxiety)		☐	☐	**NA**	
Cardiovascular (Heart Disease, High Blood Pressure)		☐	☐	☐	
Respiratory (Asthma, COPD)		☐	☐	☐	
Gastrointestinal (Acid Reflux, Ulcers, Crohn’s, IBS)		☐	☐	☐	
Genitourinary (Kidney, Prostate, STD)		☐	☐	☐	
Muscles/Bones/Joints (Arthritis, Pain)		☐	☐	☐	
Integument/Skin (Eczema, Rosacea)		☐	☐	☐	
Endocrine (Diabetes, Thyroid)		☐	☐	☐	
Blood/Lymphatic (Cholesterol, Anemia, Cancer)		☐	☐	☐	
Allergic/Immunologic (Allergy, Autoimmune)		☐	☐	☐	
Eyes	Glaucoma	☐	☐	☐	
	Cataracts	☐	☐	☐	
	Macular Degeneration	☐	☐	☐	
	Retinal Disorders	☐	☐	☐	Tobacco: ☐ Yes ☐ No
	Blindness	☐	☐	☐	Alcohol: ☐ Yes ☐ No
	Eye Turn/Lazy Eye	☐	☐	☐	Illicit Drugs: ☐ Yes ☐ No
	Eye Injuries/Surgeries	☐	☐	**NA**	Occupation:

Drug Allergies:

Additional Medical History:

Signature____ Date____________________________