WELCOME TO TUSKAWILLA FAMILY EYECARE!
DR. DAVID E. HANKINS

NAME:_____**DATE:**_____

EMAIL: _____ **SOCIAL SEC#**_____

BIRTH DATE:_____**AGE**_____ **SEX: M F MARITAL STATUS: S M D W**

ADDRESS_____**CITY**_____**ST**_____**ZIP**_____

TELEPHONE:(HOME)_____**(WORK)**_____**(CELL)**_____

OCCUPATION_____

EMPLOYER_____**HOW WERE YOU REFERRED TO OUR OFFICE?**_____

HOW LONG HAS IT BEEN SINCE YOUR LAST EYE EXAM?_____

DO YOU WEAR CONTACT LENSES? YES_____**NO**_____**ARE YOU INTERESTED IN CONTACTS?**_____

ARE YOU INTERESTED IN LASER VISION CORRECTION (LASIK)?_____

INSURANCE COMPANY_____

PHONE NUMBER OF INSUR. CO:_____**POLICY/ ID NUMBER**_____

WHAT IS THE MAIN REASON YOU CAME INTO OUR OFFICE TODAY?_____

HEALTH HISTORY

	PERSONAL HISTORY		FAMILY HISTORY		MEDICATIONS
	YES	NO	YES	NO	YOU TAKE NOW
HEART DISEASE					
HIGH BLOOD PRESSURE					
CHOLESTEROL					
KIDNEY PROBLEMS					
ULCERS					
THYROID PROBLEMS					
HEADACHES					
DIABETES					
LUNG DISEASE					
CANCER					
ARTHRITIS					
SINUS DISORDER					
ALLERGIES					
ASTHMA					
GLAUCOMA					
CATARACTS					
OTHER EYE DISEASES					
ALLERGY TO MEDICINE	Y	N	IF YES, WHICH MEDICATION:		
DO YOU USE	TOBACCO: Y N	ALCOHOL: Y N	OTHER DRUGS: Y N		

I understand that I am ultimately responsible for all charges related to my eye care and materials obtained from Dr. David Hankins, and I agree to pay these charges in the event my insurance fails to cover the charges, or any part of the charges, for any reason.

SIGNATURE_____**DATE**_____