Welcome back! ***David R. King, O.D.***

History Update for Returning Patients

Name:_____ Today's Date:_____

Address_____ City_____ Zip_____ Home Ph:_____

Email address:_____ Cell ph #:_____ Wk Ph:_____

OK to text appointment reminder? ☐ Yes ☐ No

Thank you for helping us to keep your file current. If you check "Yes" to any of these questions, please fill in the new information on the line that follows.

In the past year have you:

Moved? ☐ Yes ☐ No

Changed employment? ☐ Yes ☐ No

Had any change in insurance information? ☐ Yes ☐ No

Changed primary physician? ☐ Yes ☐ No

Been diagnosed with a new health problem? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

(please list):

Had a family member diagnosed with glaucoma or macular degeneration? ☐ Yes ☐ No

(please circle which condition)

Any allergies to medications? ☐ Yes ☐ No

(please list):

Any changes noticed with your eyes or your vision? ☐ Yes ☐ No

(If "Yes", what changes?)

Are you planning on getting new glasses today? ☐ Yes ☐ No

Interested in trying: *Contact lenses?* ☐ Yes ☐ No *Refractive surgery?* ☐ Yes ☐ No

I acknowledge that the information is true. I also request payments of this claim and, if the payer accepts assignment, I authorize release of medical records to process any claims. I authorize payment of health care benefits to this office. I understand that I am responsible for payment of any charges not covered by my insurance.

Signature X_____ **Date**_____