LIANNE M. PINO, OD PA
EXCEPTIONAL VISION

Patients Personal Information

Name____ Date of Birth____________________ Age____________
(Last) (First) (MI)
(Title) Dr. Mr. Mrs. Ms. Other_______________ Sex (Please Circle) Male Female

If child, parent's name____________________________ Social Security Number________ ________ ________

Address_______________________________________ Employer/ School______________________________________

City________________State______ Zip Code________ Occupation____

Home Telephone________________________________ Referred by____

Daytime Telephone______________________________ Insurance Name____

Cellular Telephone_______________________________ Insurance Member Name________________________________

Email Address__________________________________ Insurance Member Id #________________________________

Insurance
Group____

Patients Health Information

Date of Last Eye Exam __________________________ Date of Last Physical Exam ___________________________

Family Doctor name_____________________ Family Doctor Telephone Number ________________________

Do you have (please circle)

High Blood Pressure	Heart Problems	Glaucoma	Eye Turn	Dry Eyes
Diabetes	Respiratory Problems	Cataracts	Headaches	Tearing
Head Injuries	thyroid Problems	Double Vision	Allergies	Itchy Eyes
Cancer				

Have you ever had (please circle no or yes- if yes, indicate when and what type)
Eye Injury No Yes______ __________ Eye Surgery No Yes______ __________________________

Do any family members have (please circle no or yes- if yes, indicate relationship of family member to you)

Glaucoma	No Yes_______________	Diabetes	No	Yes ____________
Macular Degeneration	No Yes_______________	Blindness	No	Yes____________
High Blood Pressure	No Yes_______________			

Do you (please circle yes or no)
Smoke Cigarettes/Cigars/Tobacco Yes No Drink Alcohol Yes No Use other substances Yes No
List current medications being taken and the reasons for taking them (use back of page for additional space, if necessary)
____
Have you ever considered Laser Vision Correction? Yes No Would you like to learn more? Yes No

Are you wearing contact lenses? Yes No If not are you interested in wearing contact lenses? Yes No

Job / Activities / Hobbies / You participate In Frequently That May Require Special Vision Care
(Please Circle)

Computer Use Yes No If, yes, state approximate number of hours per day___________________________

Boating Fishing Golf Tennis Reading Baseball Basketball Soccer other_______________________

I authorize release of any medical or other information necessary to process any insurance claim. I also request payment of government benefits either to myself or to the party who accepts the assignment. I authorize payment of medical benefits to Dr. Lianne Pino for services rendered.

____ ___________________________
Lifetime Patient Signature Date