

**Welcome** to the office of  
Daniel R. Obermark, O.D.

**Thank you** for choosing our practice for your eye care needs.  
Please help us help you by completing this form.  
If you have any questions or concerns, please ask, we are happy to help.

**Please present your insurance cards to the receptionist.**

Patient's Name: Miss / Mrs. / Mr. / Dr. \_\_\_\_\_ Please correct any errors or changes.  
Person responsible for bill \_\_\_\_\_  
Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Patient's Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_  
Patient's Occupation \_\_\_\_\_ Office Phone \_\_\_\_\_  
Employer / School \_\_\_\_\_ Grade \_\_\_\_\_

**How were you referred to us?** Please check and fill in the blank.

- Person's Name \_\_\_\_\_  
 Doctor's or Optician's Name \_\_\_\_\_  
 Yellow Pages  Newspaper  Sign  Radio  
 Other \_\_\_\_\_

Have you ever worn glasses?  Yes  No

If so, are they bothersome to you?  Yes  No

Have you ever worn contact lenses?  Yes  No

If so, what type of lenses? \_\_\_\_\_

If you are wearing contact lenses, who prescribed them? \_\_\_\_\_

Are you interested in new contacts?  Yes  No

Have you considered Laser Vision Correction?

Yes  No

**To help us make the best recommendation for your eye care needs, Please list work related visual needs.**

Computer  Driving  Other \_\_\_\_\_

**Also, please list your hobbies or leisure activity.**

Crafts/Sewing  Hunting/Fishing  Sports

Other \_\_\_\_\_

**Other family members.**

(If they have been a patient of ours, please put a check in the box by their name.)

If married, name of spouse \_\_\_\_\_

Name of Children \_\_\_\_\_ Ages \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical History:**

Please name your medical doctor: \_\_\_\_\_

Do you or have you ever had:

	NO	YES	Explain / List Medications you take
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Drug Allergies: List any medication you cannot take:  No known drug allergies

Penicillin  Sulfa  Codeine  Aspirin

Other:

Are you pregnant and / or nursing  No  Yes

List any Birth Control / Hormones \_\_\_\_\_

Do you use tobacco products  No  Yes

If yes, type / amount / how long \_\_\_\_\_

**Family History:**

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

	NO	YES	?	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I acknowledge full financial responsibility for services rendered by Dr. Daniel R. Obermark.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I further authorize and request that insurance payments be made directly to Dr. Daniel R. Obermark.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ (Date Updated \_\_\_\_\_ Initial \_\_\_\_\_)

**FEES DUE UPON SERVICES RENDERED.** Please check your preferred method of payment:

Cash

Check

Credit Card