# Patient Information and Insurance Consent

***Dr. Channing A Baird and Associates***

***Washington Park * City Park West***

*Thank you for choosing Eyes of The World. We look forward to serving you.*

Name_____MI:_____Last:_____

Address: _____House/Apt#:_____

City: _____State:_____Zip:_____

Preferred Phone: _____Work Phone: _____

Email: _____

Who can we thank for referring you? _____

Are you: Minor Single Married Other

Date of Birth: _____

Occupation: _____ Employer: _____

Spouse's/Parent's Name: _____

Spouse's/Parent's Workplace: _____

***There are two types of insurances that cover your eyes. Routine Vision Insurance covers your annual examination. Your Medical Insurance covers any other office visits, i.e. injury or infections.***

Reason for today's exam: Routine / Medical / Other: _____

Date of last Exam: _____ Previous Doctor: _____

Vision Insurance: _____

Relationship to Primary Member: _____

Patient's S.S. #:_____Primary Member S.S. #:_____

Primary Member Date of Birth (If other than self): _____

Medical Insurance Provider: _____

I.D. #:_____

**MEDICAL HISTORY**:

Do **you or anyone in your immediate family** have a history of the following?

Diabetes Cancer Blindness HBP Thyroid Glaucoma Turned/Lazy Eye Cataracts Macular Degeneration

Do **you** have any of the following conditions?

Any Eye Surgery Dry Eye Headaches Eye Infections/Problems Pregnant/given birth last 6 months

Are you being treated for anything medically? _____

Please list any prescription medications: _____

List any medications you are allergic to: _____