Welcome

"Clear vision begins with healthy eyes"

Nazir Khawaja, M.D., F.A.A.O.

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns do not hesitate to ask for assistance. We will be happy to help.

Patient Information:

Name:____ Date:____________

Address:____ City:____________

State:________ Zip:____________ Birth Date:____________ Gender:____________

Home Phone:_____________________ Work Phone:_________________

Are you: Minor___ Married___ Divorced:___ Single:___ Widowed:___

Your or your parents employer:______________________________

Spouse's or Parent's name:__________________ Work Phone:__________________

If you are a student, name of school/college__________________________________

Whom may we thank for referring you to us?__________________________________

Person to contact in case of emergency:__________________ Phone#:____________

Insurance Information:

Name of insured:_______________________ Relationship to patient:____________

Birth Date:__________ Soc. Security #:________________________

Name of employer:_______________________ Work Phone:___________________

Insurance Co.______________ Member #:______________ Group #:____________

Please note: It is the policy of this office that payments be made at the time of visit. Unless your insurance policy includes specific vision benefits, routine eye exams are generally not covered unless you have a medical eye condition.

Health History:

Name:____ Age:________

Reason for today's exam:____

Date of last exam:____________________ Name of eye Dr.________________
Name of family Physician:__________________________________

Do you or anyone in your family have a history of any of the following?
____Diabetes ____Blindness ____High Blood Pressure ____ Cataracts
____ Thyroid ____ Turned or Lazy eye ____Glaucoma ____ Heart Condition

Please check any of the following conditions that apply to you:
____ Frequent Headaches ____ Drug Allergies ____ Sinus Allergies
____ Pregnant ____ Have given birth in the last 6 months
Any other medical conditions:____
Please list all medications you are currently taking:___________________________
____

Have you ever had any of the following conditions involving your eyes?
____ Eye Surgery ____ Sensitivity to light ____ Eye Infection or disease
____ Eye Injury ____ Floaters or spots ____ Double vision ____ Dry eyes
____ Retinal Problems ____ Poor Distance Vision ____ Eye Strain
____ Poor Near Vision ____ Severe Pain ____ Eyes burn, itch or water

Do you currently wear glasses? ____ Yes ____No
When do you wear your glasses? ____ All the time _____ Computer work
_____ Work safety ____ Reading/Near tasks ____ Distance tasks
Have you ever worn contacts? ____Yes ____ No If yes, what brand?_____________
Are you interested in wearing contact lenses? ____ Yes ____ No
Do you work at a computer or terminal? ____ Yes ____ No

I certify that I have read and understand the above information and the above questions have been accurately answered. I authorize the eye doctor to release any information including the diagnosis and the prescription rendered to me or my child during the period of such eye care to third party payers and request my insurance company to pay directly of payment of all services rendered on my behalf or my dependants. I have been presented with a copy of Covington Vision Center's notice of privacy policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this notice, and I request the following restriction(s) concerning the use of my personal medical information.

Signature of Patient (or parent if minor) ______________________________________