Dr. David J. Tabak
OPTOMETRY

Date: _____

Last Name:_____ **First:**_____ **MI:** ___

Address: _____ **Apt:** _____

City: _____ **State:**_____

Zip Code: _____ **Birth Date:** _____ **SS#:**_____

Circle preferred method of contact: **Voice Call** **Text** **Email**

Phone Number: H : _____ **W :** _____ **C :** _____

Email: _____

Check which applies

Gender
- ☐ Female
- ☐ Male

Preferred Language
- ☐ English
- ☐ German
- ☐ Spanish

Conditions that relate to your parents, children or siblings:
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Macular Degeneration
- ☐ Other _____

Conditions that relate to you
- ☐ Allergies
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Dry Eye
- ☐ Eye Infection, Inflammation
- ☐ Floaters and/or flashes of light
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Iritis or Uveitis
- ☐ Macular Degeneration
- ☐ Retinal Defects
- ☐ Other _____

Name and ID # of your primary medical insurance:_____

Are you covered by a vision plan? ☐ Yes ☐ No

If yes, what is the name of the vision plan: _____

Member ID #: _____

Primary Insurance Holder: Same as above ☐ Yes ☐ No

(If no; complete the following)

Name: _____

Address: _____

Phone:_____

Birth Date:_____ SS#_____ **OVER--->**

Relationship to Patient:_____

530 N. Hough St. #140 Barrington, IL 60010
847-382-2020 www.davidtabakod.com

Dr. David J. Tabak
OPTOMETRY

Employer: _____

Occupation: _____

Referred By:_____

Date of last Eye Exam:_____

Primary Care Physician: _____

Are you currently taking any medication(s)? ☐ Yes ☐ No

If so, what?_____

Do you suffer from headaches? ☐ Yes ☐ No If yes, how frequently?_____

Do you currently wear eyeglasses? ☐ Yes ☐ No

Do you currently wear contacts? ☐ Yes ☐ No

If you wear glasses or contacts, are they clear and comfortable? ☐ Yes ☐ No

How many hours a day do you use an electronic device? _____

Acknowledgment of Receipt

I acknowledge that a copy of Dr. David J. Tabak's Notice of Privacy Practices was made available to me. If using insurance to cover any of my charges I agree to pay any deductibles, copays or non-covered services.

Patient Signature (Or Guardian):_____

Date:_____

Please return to Receptionist,
Thank you

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