Dr. Aimee Noll, OD
2645 St Rose Pkwy, Ste C-110
Henderson, NV 89052
(702) 665-4960
www.draimeenoll.com

Patient Legal Name:____ Gender: M____F____

SS#:____ Date of Birth: _______________________

Mailing Address:____ Apt: _____________

City:____________________________________ State:___________ Zip:______________________

Phone Number:____(home/cell/work)

EMAIL Address:____

Occupation:________________________________ Employer:______________________________

Insurance Information:

Primary Holder Name:________________________________ Relationship to patient: _________

Date of Birth:_________________________ Last 4 SS#: _________________________

Medical History:

Date of Last Eye Exam:___________________ Date of Last Physical Exam:___________________

Medical Conditions:____

Medications: ____

Drug Allergies:____

Family History:

Does your mom/dad/brother/sister have any of the following?: (please circle)

Cancer, Diabetes, Thyroid condition, Hypertension

Macular Degeneration, Cataract, Glaucoma

I authorize the release of medical or other information to process the claim and payment to the party who accepts assignment. I acknowledge all the information entered is correct and accurate.I accept the financial responsibility for all expenses on today's visit and understand payment is due when service is provided. If insurance fails to pay, the patient will be responsible for any materials or services not covered. Failure of payment will be sent to collections. I authorize payment of my insurance benefits to Aimee Noll, OD.

Patient/Parent/Guardian Signature:_________________________________ Date:_____________