

PATIENT INFORMATION

Thank you for choosing our practice for your eyecare 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.

(Please Print)

Name _____ Date _____ Patient No. _____
First MI Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home phone # _____ Work phone # _____

Do you prefer to receive calls at: Home Work Either

Are You: Minor Married Divorced Widowed Single Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Workplace _____ Work phone # _____

If you are a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Do you have a flexible spending account at work? Yes No

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

HEALTH HISTORY

Name _____ Age _____

Reason for today's exam _____

Date of last exam _____ Name of eye doctor _____

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

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Turned or lazy eye |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Macular degeneration |

Please check any of the following conditions that apply to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Drug allergies | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Have given birth in the last 6 months |

Please list all medications you are currently taking: _____

Have you ever had any of the following conditions involving your eyes?

- | | | |
|--|---|--|
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Eye infection or disease |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> Floaters or spots | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Poor distance vision | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Severe pain | <input type="checkbox"/> Poor near vision | <input type="checkbox"/> Eyes burn, itch, or water |

Do you currently wear glasses? Yes No

When do you wear your glasses?

- | | |
|--|--|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Reading/near work |
| <input type="checkbox"/> Work safety | <input type="checkbox"/> Distance tasks only |
| <input type="checkbox"/> Computer work | <input type="checkbox"/> Other, please explain _____ |

Have you ever worn contacts? Yes No

Are you interested in wearing contact lenses? Yes No

If so, what style?

- | | | | |
|---------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Soft | <input type="checkbox"/> Extended Wear | <input type="checkbox"/> Gas Permeable | <input type="checkbox"/> Bifocal |
| <input type="checkbox"/> Tinted | <input type="checkbox"/> Astigmatic | <input type="checkbox"/> Disposable | <input type="checkbox"/> Unsure |

Do you work at a computer or video display terminal? Yes No

What hobbies or sports do you participate in? _____

Do you smoke? _____

Please provide e-mail address : _____

X

SIGNATURE OF PATIENT (Or parent if a minor)

DATE