

PATIENT FORM

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GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer

full-time | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

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EYE HISTORY

Date of Last Eye Exam _____

Currently Wear Glasses? _____

Currently Wear Contacts? _____

Reason for Today's Visit _____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts yes no family

Crossed Eye yes no family

Glaucoma yes no family

LASIK or RK yes no family

Lazy Eye yes no family

Macular Degeneration yes no family

Retinal Detachment yes no family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

Blurry Vision *near or distance*

Burning

Discharge

Double Vision

Dryness

Excess Tearing/Watering

Eye Infection

Eye Pain or Soreness

Floaters or Spots

Halos

Headaches

Itching

Light Flashes

Light Sensitivity

Redness

Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV yes no family

Allergies yes no family

Arthritis yes no family

Asthma yes no family

Blood/Lymph Disorder yes no family

Cancer yes no family

Diabetes yes no family

Ears, Nose, Throat Conditions yes no family

Gastrointestinal Conditions yes no family

Heart Disease yes no family

High Blood Pressure yes no family

High Cholesterol yes no family

Kidney Disease yes no family

Lupus yes no family

Neurological Conditions yes no family

Psychiatric Disorder yes no family

Seizures yes no family

Skin Conditions yes no family

Stroke yes no family

Thyroid Dysfunction yes no family

**Current Medications
(prescription and over-the-counter and dosage)**

Medication Drug Allergies

Height Weight

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?