Welcome to our office

All information in this form is strictly confidential

Date _____ / _____ / _____

First Name ____________________ Home Address ____________________

Last Name ____________________ City ____________ State _____ Zip _____

Date of Birth _______ / _______ / _______ Phone (home) ____________________

Age __________ Sex: ❐ Male ❐ Female (cell) ____________________

OK to text appointment reminder? ❐ Yes ❐ No

Email ____________________

Occupation (or grade) ____________________

How did you hear about our office? ❐ Dr. Referral ❐ Friend ❐ Internet ❐ Walk-in ❐ Insurance

Insurance Information

Insurance Co. ____________________ Policy Holder (if not patient) ____________

Policy Holder Birthdate _____ / _____ / _____

Employer ____________________ Relationship ____________________

Policy # ______________ Group ________

Family Medical History

Is there a family medical history of any of the following?

		Relationship			Relationship
Blindness	❐ Yes ❐ No	________	Macular Degeneration	❐ Yes ❐ No	________
Glaucoma	❐ Yes ❐ No	________	Corneal Disease	❐ Yes ❐ No	________
Lazy Eye	❐ Yes ❐ No	________	Retinal Disease	❐ Yes ❐ No	________
Diabetes	❐ Yes ❐ No	________	Crossed Eyes	❐ Yes ❐ No	________

Personal Medical History

Primary Medical Doctor ____________ Clinic __________ Phone # ____________

Are you allergic to any medications? ❐ Yes ❐ No if yes, please list: ____________

____

Are you taking any medications? ❐ Yes ❐ No Please list any medications you take (including over the counter and eye drops) ____________________

____

Do you: ❐ Smoke? ❐ Drink alcoholic beverages? ❐ Use illegal drugs?

Please turn over and complete other side →

Do you currently, or have you ever had any problems in the following areas?

☐ Yes ☐ No Constitution ________________ ☐ Yes ☐ No Genito /Urinary ________________

☐ Yes ☐ No Ear/Nose/Throat ________________ ☐ Yes ☐ No Musc/Skel ________________

☐ Yes ☐ No Neuro ________________ ☐ Yes ☐ No Skin ________________

☐ Yes ☐ No Psych ________________ ☐ Yes ☐ No Diabetes Type? ________________

☐ Yes ☐ No Cardiovasc ________________ ☐ Yes ☐ No Hem/Lymph ________________

☐ Yes ☐ No Respiratory ________________ ☐ Yes ☐ No Allergy/Imm ________________

☐ Yes ☐ No Gastro/Intestinal ________________ Other ________________

Personal Eye History

Date of Last Exam ________________ Last Eye Dr. ________________

Are you planning on purchasing glasses today? ________ Any past eye surgeries? ________

Do you wear contact lenses? ☐ Yes ☐ No Are you interested in wearing contacts? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following?

Diabetic Retinopathy	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Eye Turn	☐ Yes ☐ No	Iritis/Uveitis	☐ Yes ☐ No
Retinal Detachment	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No	Eye Injury	☐ Yes ☐ No

Do you experience the following symptoms?

Gritty or sandy sensation	☐ Yes ☐ No	Blurry vision at distance even with glasses	☐ Yes ☐ No
Eye pain	☐ Yes ☐ No	Blurry vision up close even with glasses	☐ Yes ☐ No
Fluctuating vision	☐ Yes ☐ No	Red, itchy, watery eyes or swollen eyelids	☐ Yes ☐ No
Flashes of light	☐ Yes ☐ No	Floaters in vision	☐ Yes ☐ No

I acknowledge that the information is true. I also request payment of this claim, and if the payer accepts assignment, I authorize release of medical records to process any claims. I authorize payment of health care benefits to this office. I understand that I am responsible for payment of any charges not covered by my insurance. NOTE: ALL RETURNED CHECKS ARE SUBJECT TO A $15 CHARGE.

Insured Signature X ________________________________ *Date* ____ / ____ / ____

FORM #180212