CONFIDENTIAL

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 ______

How much is your deductible? __________ How much have you used? __________ Max. annual benefit __________

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 ______

How much is your deductible? __________ How much have you used? __________ Max. annual benefit __________

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?

- ☐ Diabetes
- ☐ Blindness
- ☐ High blood pressure
- ☐ Cataracts
- ☐ Thyroid
- ☐ Turned or lazy eye
- ☐ Glaucoma
- ☐ Heart condition

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

- ☐ Frequent headaches
- ☐ Drug allergies
- ☐ Pregnant
- ☐ Allergies
- ☐ Sinus trouble
- ☐ 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?

- ☐ Eye surgery
- ☐ Sensitivity to light
- ☐ Eye infection or disease
- ☐ Eye injury
- ☐ Floaters or spots
- ☐ Double vision
- ☐ Medical treatment
- ☐ Poor distance vision
- ☐ Eye strain
- ☐ Severe pain
- ☐ Poor near vision
- ☐ Eyes bum, itch, or water

Do you currently wear glasses? ☐ Yes ☐ No

When do you wear your glasses?

- ☐ All the time
- ☐ Reading/near work
- ☐ Work safety
- ☐ Distance tasks only
- ☐ Computer work
- ☐ Other, please explain ______________________________

Have you ever worn contacts? ☐ Yes ☐ No

Are you interested in wearing contact lenses? ☐ Yes ☐ No

If so, what style?

- ☐ Soft
- ☐ Extended Wear
- ☐ Gas Permeable
- ☐ Bifocal
- ☐ Tinted
- ☐ Astigmatic
- ☐ Disposable
- ☐ Unsure

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

What hobbies or sports do you participate in? ______________________________

X ______________________________

SIGNATURE OF PATIENT (Or parent if a minor) DATE