Patient Information

Date: _____/_____/_____

Legal Name: _____ **Preferred Name:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Email: _____ **Preferred Contact Method:** Cell Phone Home Phone Text Message

Social Security #: XXX – XX - _____ **Birthday:** _____/_____/_____ **Sex:** M F

Occupation: _____ **Employment Status:** Employed Retired Student

Marital Status: _____ **Parent(s)/Guardian(s):** _____

Is the billing address different than the address listed above? YES NO

Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

If you have already given us your insurance cards, only fill in information about Primary Insurance Holder.

Primary Vision Insurance

Insurance Name: _____ **Insurance ID:** _____

Primary on Account Name: _____ **Sex:** M F

Relationship to Insured: Spouse Child Self Other: _____

Primary Holder's Birthday: _____/_____/_____ **Primary Holder's Social Security #:** XXX – XX - _____

Secondary Vision Insurance

Insurance Name: _____ **Insurance ID:** _____

Primary on Account Name: _____ **Sex:** M F

Relationship to Insured: Spouse Child Self Other: _____

Primary Holder's Birthday: _____/_____/_____ **Primary Holder's Social Security #:** XXX – XX - _____

Primary Medical Insurance

Insurance Name: _____ **Insurance ID:** _____

Insurance Policy Group: _____

Primary on Account Name: _____ **Sex:** M F

Relationship to Insured: Spouse Child Self Other: _____

Primary Holder's Birthday: _____/_____/_____ **Primary Holder's Social Security #:** XXX – XX - _____

Secondary Medical Insurance

Insurance Name: _____ **Insurance ID:** _____

Insurance Policy Group: _____

Primary on Account Name: _____ **Sex:** M F

Relationship to Insured: Spouse Child Self Other: _____

Primary Holder's Birthday: _____/_____/_____ **Primary Holder's Social Security #:** XXX – XX - _____

What is your occupation? _____

Hours per day looking at a screen? _____

Are you experiencing any of the following?

Blurred Vision	Screen Fatigue	Double Vision
Flashing Lights	Floating Spots	Itchy/Watery
Eyestrain	Redness	Dryness
Burning	Glare	

Any other eye or vision problems? _____

_____

Are you interested in: Contacts / Lasik / Neither

Ocular History:

Lazy Eye	YES	NO
Cataracts	YES	NO
Age-Related Macular Degeneration	YES	NO
Glaucoma	YES	NO
Diabetic Retinopathy	YES	NO
Dry Eye	YES	NO
Eye Infection, Inflammation, or Allergy	YES	NO
Floaters and/or Flashes of Light	YES	NO
Iritis or Uveitis	YES	NO
Retinal Defect or Detachment	YES	NO
Eye Surgery or Injury Please List:	YES	NO
Other		

Please list all medications you are taking and the condition being treated:

MEDICATION	CONDITION

If you need more space, please continue on the back

Do you wear corrective lenses?

Glasses Contacts Both Neither

Family History: please indicate if any relatives have the following conditions. If yes, please list their relation to you
(Grandmother, Grandfather, Mother, Father, Sibling, or Child)

		If Yes, List each Relation
Cancer	NO	
Diabetes	NO	
Hypertension	NO	
Thyroid	NO	
High Cholesterol	NO	
Cardiovascular	NO	
Macular Degeneration	NO	
Glaucoma	NO	
Other	NO	

Personal History: Circle at least 1 per line

General:	Pregnant/Nursing	Cancer	Other	None
Ear/Nose/Throat:	Hearing Loss	Dry Mouth	Other	None
Neuro:	Multiple Sclerosis	Migraines	Autism	Other None
Psych:	Depression	Anxiety	Attention Deficit	Other None
Cardio:	Hypertension	Stroke	Heart Disease	Other None
Respiratory:	Asthma	Sleep Apnea	Other	None
Gastrointestinal:	Crohn's	Colitis	Acid Reflux	Other None
Genitourinary:	Kidney Disease	Other	None	
Musc/Skel:	Osteoporosis	Ankylosing Spondylitis	Other	None
Skin:	Rosacea	Eczema	Psoriasis	Other None
Endocrine:	Diabetes – T1 / T2	Thyroid Issues	Other	None
Blood/Lymph:	High Cholesterol	Anemia	Other	None
Allergy/Immune:	Allergies	Arthritis	Other	None

Other: _____

_____

Are you allergic to any medication(s)? Yes / No

If yes, please list: _____

_____

Alcohol Use? Yes / No

Drinks per day _____ or Drinks per week _____

Smoking Status? Never / Former / Current

Cigarettes per day _____ or Packs per week _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes.

Print: _____ **Sign:** _____ **Date:** _____