PATIENT INFORMATION

Date___/ ___/____

Last Name________________________ First Name_____________________ ☐ M ☐ F DOB___/ ___/____

Address____ City_________________ State____ Zip ______________

Cell # (___)___________ Secondary Phone (___)______________Email______________________________________

Employer_______________________ Occupation____________________

What is the Reason for Today's Exam? ____

____

INSURANCE INFORMATION

Primary Health Insurance_________________ Insured Name____________________ Insured ID#_________________

Vision Insurance_________________ Insured Name____________________ Insured ID#_________________

Insured DOB___________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

MEDICAL AND OCULAR HISTORY

Date of Last Eye Exam___/ ___/____ From Dr. ______________

Date of Last Primary Care Doctor Appointment: ___/ ___/____ From Dr/Office.___________________________

Current medications (Rx or OTC) (List name of medications including eye drops, vitamins, & birth control pills)

____

____

Allergies to medications? __Yes __No. If yes, list them here____

Please list any surgeries and dates if applicable____

Do you use cigarettes/tobacco? __Yes__No If yes, how often? ___________Do you use alcohol? __Yes __No

GENERAL HEALTH			
	YES	NO	IN FAMILY
Diabetes			
High Blood Pressures			
Heart Disease			
Headache			
Thyroid			
Arthritis			
Cancer			
Allergy/Sinus			
Other:			

EYE HISTORY			
	YES	NO	IN FAMILY
Glaucoma			
Macular Degeneration			
Cataracts			
Retinal Detachment			
Lazy Eye			
Eye Surgery			
Eye Injury			
Color Blindness			
Other:			

Patient Name ____

Patient/GuardianSignature____Date:_____________