Welcome

Please fill out completely. Insurance may not pay if we cannot provide all information

PATIENT INFORMATION

Name _____ Social Security #_____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Email Address (please write legibly) _____(Used to contact you & NEVER shared)

Phone Numbers: Home _____ Work _____ Cell _____ [ ] OK to text

Date of Birth _____ Age _____ Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Name of Spouse/Parent _____ Last eye exam _____ By whom? _____

Occupation _____ Employer _____

List of other family members we have seen _____

PERSON RESPONSIBLE FOR THE BILL (If different from patient) _____

Method of Payment: Cash [ ] Check [ ] Credit Card [ ] Medicare [ ] Medicaid [ ] Insurance [ ]

INSURANCE INFORMATION

Vision Insurance Company: _____ Medical Insurance Company: _____

MEDICAL HISTORY

List all medications you take (skip if you have a written list):

_____

Do you have any drug allergies? Yes [ ] No [ ] Which medications? _____

Please circle any of the following you have had: Crossed eyes, lazy eye, drooping lids, glaucoma, retinal disease, Cataracts, eye injuries, other: _____

FAMILY HISTORY

Family history of the following (Family being parents, grandparents, siblings, aunts or uncles)

Disease/Condition	Yes	No	Their relationship to you
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Crossed Eyes	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	_____
Retinal Disease	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Heart Disease	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	_____
Other _____	[ ]	[ ]	_____

SOCIAL HISTORY

Do you smoke? Yes [ ] No [ ] How many years? _____ Do you drink alcohol? Yes [ ] No [ ]

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

	Yes	No
Eyes		
Blur	[ ]	[ ]
Driving at night	[ ]	[ ]
Difficulty reading	[ ]	[ ]
Double vision	[ ]	[ ]
Dry eyes	[ ]	[ ]
Redness	[ ]	[ ]
Itching	[ ]	[ ]
Burning	[ ]	[ ]
Watering/Excess Tearing	[ ]	[ ]
Glare/Light sensitivity	[ ]	[ ]
Pain or soreness	[ ]	[ ]
Flashes of light	[ ]	[ ]
Floaters	[ ]	[ ]
Tired eyes	[ ]	[ ]
Endocrine		
Diabetes	[ ]	[ ]
Thyroid	[ ]	[ ]
Constitutional		
Fever, Weight gain/loss	[ ]	[ ]
Integumentary (Skin)	[ ]	[ ]
Neurological		
Headaches/Migraines	[ ]	[ ]
Seisures	[ ]	[ ]

	Yes	No
Ears, Nose, Throat, Mouth		
Allergies/Hayfever	[ ]	[ ]
Sinus Congestion	[ ]	[ ]
Chronic Cough	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
Bronchitis	[ ]	[ ]
Emphysema	[ ]	[ ]
Vascular/Cardiovascular		
Heart	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Vascular Disease	[ ]	[ ]
Bones/Joints		
Arthritis	[ ]	[ ]
Osteoporosis	[ ]	[ ]
Lymphatic/Hematologic		
Anemia	[ ]	[ ]
Free Bleeder	[ ]	[ ]
Gastrointestinal	[ ]	[ ]
Genitourinary	[ ]	[ ]
Psychiatric	[ ]	[ ]