PERSONAL INFORMATION

PATIENT NAME ☐ MS. ☐ MRS. ☐ DR. ☐ MISS ☐ MR.	DATE OF BIRTH	SOCIAL SECURITY#

ADDRESS	CITY	STATE	ZIP

HOME PHONE	DAYTIME PHONE	CELL PHONE	OCCUPATION	EMPLOYER

GRADE & SCHOOL	COMPUTER USE ☐ YES ☐ NO HOURS: DO YOU WEAR COMPUTER GLASSES ☐ YES ☐ NO	HOBBIES	NAME of PARENTS/SPOUSE

LIST ANY FAMILY MEMBERS WE HAVE SEEN:	E-MAIL ADDRESS

GUARANTOR INFORMATION (if different from above)

NAME & ADDRESS	BIRTHDATE	SOCIAL SECURITY #

HOME PHONE	BUSINESS PHONE	OCCUPATION	EMPLOYER

MEDICAL HISTORY

NAME OF FAMILY PHYSICIAN & PHONE #	NAME OF LAST EYE DOCTOR PHONE # & DATE

WHAT IS THE MAIN REASON FOR YOUR FOR YOUR VISIT TODAY?

ARE YOU INTERESTED IN LASER VISION CORRECTION? ☐ YES ☐ NO

ARE YOU INTERESTED IN VITAMIN SUPPLEMENTS TO SLOW AGING OF EYES? ☐ YES ☐ NO

CIRCLE ANY THAT APPLY TO YOU: ALCOHOL ABUSE ALLERGIES ARTHRITIS ASTHMA CANCER DIABETES DRY EYES HEADACHES HEAD TRAUMA HEART DISEASE ILLEGAL DRUG USE ITCHY EYES HIGH BLOOD PRESSURE LUNG DISEASE RED EYES SEIZURES SINUSITIS SMOKER SUNGLASS WEARER VASCULAR DISEASE

OTHER(S) LIST ____________________

LIST ANY MEDICATIONS INCLUDING OTC & EYE DROPS AND WHY YOU TAKE THEM

____

____

LIST ANY ALLERGIES TO MEDICATIONS ____________________

CIRCLE ANY EYE CONDITIONS THAT APPLY TO YOU

CONTACTS DRY EYES EYEGLASSES EYE INJURY GLAUCOMA LAZY EYE MACULAR DEGENERATION REFRACTIVE SURGERY TURNED EYE VISION THERAPY

OTHER EYE DISEASES or SURGERIES (LIST) ____________________

CIRCLE ANY CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS

CATARACTS DIABETES GLAUCOMA HEART DISEASE HIGH BLOOD PRESSURE MACULAR DEGENERATION

OTHER EYE DISEASES ____________________ OTHER INHERITED CONDITIONS ____________________

LIST CHILDREN LIVING AT HOME & AGES ____________________

CONTACT LENS HISTORY

☐ NEVER WORN CONTACTS
☐ NOT INTERESTED IN CONTACTS
☐ WOULD LIKE TO KNOW MY OPTIONS

WHAT SOLUTIONS DO YOU USE? ____________________

____

____

HOW OFTEN DO YOU CLEAN YOUR LENSES? ____________________

TYPE OF CONTACT LENSES ____________________

AGE OF CURRENT PAIR ____________________

LIST ALL TYPES OF CONTACTS YOU HAVE TRIED ____________________

____

LIST ANY PROBLEMS WITH CONTACT LENSES ____________________

____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

☐ MAILOUTS ☐ PHONE BOOK ☐ NEWSPAPER ☐ TELEVISON ☐ LOCATION ☐ INS. CO. LIST ☐ DIRECT ☐ REFERRAL ____________________

PLEASE PROVIDE VISION AND HEALTH INSURANCE INFORMATION

PRIMARY'S NAME ____________________ PRIMARY'S BIRTHDAY ____________________ PRIMARY'S SS# ____________________

RELATIONSHIP TO PATIENT ____________________

VISION INSURANCE COMPANY ____________________ POLICY# ____________________

HEALTH INSURANCE COMPANY ____________________ POLICY# ____________________ GROUP# ____________________

MEDICARE ____________________