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? ____

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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. _______________

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

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____

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:_____________