

# PATIENT FORM

PAGE 1 OF 2

## GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer

*full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

## INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

# PATIENT FORM

PAGE 2 OF 2

## EYE HISTORY

Date of Last Eye Exam \_\_\_\_\_

Currently Wear Glasses? \_\_\_\_\_

Currently Wear Contacts? \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.**

Cataracts                      yes      no      family

Crossed Eye                      yes      no      family

Glaucoma                      yes      no      family

LASIK or RK                      yes      no      family

Lazy Eye                      yes      no      family

Macular Degeneration                      yes      no      family

Retinal Detachment                      yes      no      family

**Are you currently experiencing, or have experienced, any of the following? Check all that apply.**

Blurry Vision                      *near or distance*

Burning

Discharge

Double Vision

Dryness

Excess Tearing/Watering

Eye Infection

Eye Pain or Soreness

Floaters or Spots

Halos

Headaches

Itching

Light Flashes

Light Sensitivity

Redness

Sandy or Gritty Feeling

## MEDICAL HISTORY

**Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.**

AIDS/HIV                      yes      no      family

Allergies                      yes      no      family

Arthritis                      yes      no      family

Asthma                      yes      no      family

Blood/Lymph Disorder                      yes      no      family

Cancer                      yes      no      family

Diabetes                      yes      no      family

Ears, Nose, Throat Conditions                      yes      no      family

Gastrointestinal Conditions                      yes      no      family

Heart Disease                      yes      no      family

High Blood Pressure                      yes      no      family

High Cholesterol                      yes      no      family

Kidney Disease                      yes      no      family

Lupus                      yes      no      family

Neurological Conditions                      yes      no      family

Psychiatric Disorder                      yes      no      family

Seizures                      yes      no      family

Skin Conditions                      yes      no      family

Stroke                      yes      no      family

Thyroid Dysfunction                      yes      no      family

**Current Medications  
(prescription and over-the-counter and dosage)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medication Drug Allergies**

\_\_\_\_\_

\_\_\_\_\_

**Height                      Weight**

**Are you pregnant or nursing?**

**Do you smoke?**

**Have you ever smoked?**