Name: _____ Birth Date: _____ Male ☐ Female ☐

Address: _____ City: _____

State: _____ Zip: _____ SSN: _____ Married ☐ Single ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer/Occupation or School attending: _____

Spouse or Parents Name: _____

Intrest/Hobbies: _____

Please list any members of your household who are our patients:

_____

Who referred you to our office today: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Previous eye doctor: _____ Date of last eye exam: _____

Name of general physician: _____ Phone: _____

How will you be paying today? Cash ☐ Check ☐ Credit or Debit ☐ Care Credit ☐ Other ☐ _____

Insurance Information

Health Insurance: _____ Policy Holder's Name: _____

Policy ID #: _____ Policy Holder's DOB: _____

Vision Insurance: _____ Policy Holder's SSN: _____

Medications

Pharmacy Name: _____ Location: _____

Please list all of your medications: _____

_____

Do you have allergies to medications or other substances? Please explain: _____

_____

Eye Health

Do you wear glasses? _____ How old are your glasses? _____ When do you wear them? _____

Do you wear contacts? _____ What brand? _____ Would you like contacts today? _____

Please circle if you have the following: Diabetes Cataracts Glaucoma Allergies

Macular Degeneration Cancer Sandy/Gritty High Blood Pressure Double Vision

Floaters or Spots Itching Dryness Discharge Pain Headaches Watering Eyes

Halos Blurred Distance Vision Blurred Intermediate Vision Blurred Near Vision

_____ _____

Signature of Patient Date