Seeing the World through Healthy Eyes

NEW Patient Information (All information provided is Confidential)

Patient Name________________ Today's Date __________ Date of Birth ____________

Address ____________________

City/State/Zip ____________________

Phone: Day ______________ Cell ______________ E-mail address ______________

Parent/Guardian (if patient is a child) ____________________

Address/Phone (if different) ____________________

Whom may we thank for referring you to our office?

☐ Other healthcare professional ______________ ☐ Family Member ______________

☐ Friend ______________ ☐ Radio ☐ Paper

☐ Yellow pages ☐ Office Web site ☐ Office sign/drive by ☐ Insurance listing

Insurance Information

Last 4 Digits of S. S. # ______________

Occupation ______________ Employer Name ______________

Vision Insurance Co. ______________ Major **Medical** Insurance Co. ______________

Name of *primary* insured ______________ Name of insured ______________

ID/Policy/Group# ______________ **ID**/Policy/Group# ______________

Date of Birth of primary insured ______________ Date of Birth of insured ______________

DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL? ☐ yes ☐ no

If so, please complete the following:

Name of insured ______________ Relationship to patient ______________

Member ID# ______________ Last 4-digits of Insured S. S. # ______________

Demographic Information

Sex __Male __Female __Married __Single __Widowed __Minor __Separated __Divorced __Partnered

Visual Information

Date of last vision exam ______________

Please check all that you are experiencing with your current correction:

Yes	Yes	Yes
☐ Blur far away	☐ Eyes itch	☐ Discharge from eyes
☐ Blur up close	☐ Eyes water easily	☐ Light sensitivity
☐ Headaches	☐ Dry eyes	☐ Motion sickness reading in car
☐ Squinting	☐ Sleepy w/reading	☐ Nausea or stomach problems
☐ Night vision problems	☐ Frequent loss of place when reading	☐ Pain in or around eyes
☐ Double vision		☐ Eye strain/tired eyes
☐ Eyes burn	☐ Reading held at 10" or less	☐ Floaters or spots

Have you had any eye injury, infection or surgery?

☐ yes ☐ no Explain ____________________

Please turn the page over to complete the backside. Thank you.

Health Information

Name: ______________________________ Age _____ Primary Care Doctor: ____________________

Review of Systems:

Do you have now or have you had:	Circle One	Explanation
1. Recent Fever	Yes/No	
2. Extreme Unplanned Weight Gain/Loss	Yes/No	
3. Ears, Nose, Throat Problems: Sinus Disease, Vertigo, Dry Mouth, Difficulty Swallowing	Yes/No	
4. Heart Disease: Angina, Heart Attack, Blood Pressure, Other	Yes/No	
5. Lung Disease: Asthma, Emphysema, Shortness Of Breath, Chronic Obstructive Pulmonary Disease, Congestion, Wheezing, Other	Yes/No	
6. Stomach Upset, Ulcer, Diarrhea, Constipation	Yes/No	
7. Urinary Problems, Prostate Discharge	Yes/No	
8. Muscle/Joint Pain or Weakness, Rheumatoid Arthritis, Other	Yes/No	
9. Skin Conditions, Nail or Hair Problems: Eczema, Psoriasis, Rosacea, Changing Skin Spots, Other	Yes/No	
10. Stroke, Seizures, Memory Loss, Weakness, Depression, Anxiety, Hallucinations, Other	Yes/No	
11. Bleeding Problems, Bruising, Anemia, Sickle Cell Disease, Other	Yes/No	
12. Endocrine: Diabetes-Indicate how long and what type	Yes/No	
13. HIV/AIDS	Yes/No	
14. Cancer-Indicate how long, what type	Yes/No	
15. Other:		

Current Medications:

Prescription ______________________________

Over-the-Counter ______________________________

Allergies to Medications: ______________________________

Form Completed by: Patient_____ Family_____ Staff_____ Other: ____________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X ____

Signature of Patient (Or parent if a minor) Date Doctor Initials/Date

CONFIDENTIAL