THANK YOU FOR SUPPLYING US WITH THE FOLLOWING INFORMATION. IF YOU ARE A RETURNING PATIENT WE APOLOGIZE FOR THE ADDED PAPERWORK BUT NEW GOVERNMENT REGULATIONS REQUIRE US TO GET ADDITIONAL INFORMATION THAT WE MAY NOT HAVE OBTAINED IN THE PAST.

IF YOU ARE A NEW PATIENT—WELCOME!—WE ARE PLEASED YOU HAVE CHOSEN OUR OFFICE FOR YOUR EYECARE NEEDS.

DATE OF APPT.___________

PATIENT FULL NAME____ BIRTHDATE______________

NAME YOU PREFER TO BE CALLED____________________________________ GENDER M F

SOCIAL SECURITY #____________________________ MARITAL STATUS_________________

PREFERRED LANGUAGE________________________ ETHNICITY________________________

PHYSICAL ADDRESS____

MAILING ADDRESS____

LOCAL OR VACATION ADDRESS____

PHONE #'S HOME___________________ CELL___________________ WORK____________________

EMAIL ADDRESS____

EMERGENCY CONTACT NAME ___________________________PHONE #________________________

EMPLOYER____ OCCUPATION______________________________

RESPONSIBLE PARTY____

MEDICAL INSURANCE COMPANY____

VISION INSURANCE COMPANY________________________________ MEMBER ID#_______________________

SUBSCRIBER NAME____ SUBSCRIBER BIRTHDATE_____________

SUBSCRIBER SOCIAL SECURITY #________________________________

HOW DID YOU HEAR ABOUT US?____

EYECARE INFORMATION

WHEN WAS YOUR LAST EYE EXAM?___________________________________

DO YOU WEAR GLASSES OR CONTACTS NOW?__________________________

ANY SPECIFIC PROBLEMS OR CONCERNS WITH EYES OR VISION_______________________________________

HISTORY OF ANY EYE SURGERIES: DATE________________ RT. EYE _____ LEFT EYE_____ BOTH______

SURGEON______________________

CONDITION OR REASON FOR SURGERY__________________________

PHYSICAL HEALTH INFORMATION

PRIMARY CARE PHYSICIAN_____________________________________

HEIGHT___________________________ WEIGHT____________________________

ANY ALLERGIES____

TOBACCO USE YES NO

CURRENT MEDICATIONS____

____

PROVIDE A LIST OF MEDICATIONS _________ INITIAL

PLEASE CHECK BELOW IF YOU HAVE/HAD ANY OF THE FOLLOWING HEALTH ISSUES OR HAVE A FAMILY HISTORY OF ANY

	SELF	FAMILY HISTORY
HIGH BLOOD PRESSURE	____	____
HIGH CHOLESTEROL	____	____
THYROID DISEASE	____	____
DIABETES	____	____
GLAUCOMA	____	____
CATARACTS	____	____
MACULAR DEGENERATION	____	____

ANY OTHER EYE CONDITIONS____

PLEASE TELL US ANYTHING ELSE THAT WILL HELP US BETTER ADDRESS YOUR EYECARE NEEDS

*IF PATIENT IS A MINOR, PLEASE COMPLETE THE ADDENDUM FOR MINORS SHEET—THANK YOU!