Welcome to our office!

Fill out your basic information below - thanks!

Name _____ Date _____

Address _____ Home Phone _____

Apt/Unit # _____ Cell Phone _____

City _____ Work Phone _____

State _____ Zip Code _____ Alternate Phone _____

Date of Birth _____ SSN _____ Email _____

Emergency Contact _____ Phone _____

Primary Care Physician _____ Phone _____

Who can we thank for referring you to us? _____

Medical Insurance Information

☐ I understand that there will be a reprocessing fee if insurance information is not presented correctly prior to examination

Insurance _____ Card # or I.D. # _____

Cardholder _____ SSN _____ Date of Birth _____

Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

_____

Vision Insurance Information

Do you have VSP (Vision Service Plan) coverage? ☐ Yes ☐ No

Insurance _____ Card # or I.D. # _____

Cardholder _____ SSN _____ Date of Birth _____

Welcome to our office!

Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

_____

Patient Demographic information

Preferred Language _____ Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Other

_____

Ethnic / Heritage Information (check at least one)

☐ Native American ☐ African American ☐ Hispanic or Latino/a

☐ Central, East, South Asian ☐ Caucasian ☐ Pacific Islander

☐ Employed Full-time ☐ Employed Part-time Occupation _____

☐ Student ☐ Retired Sports/Hobbies _____

I wear: ☐ glasses ☐ contact lenses: ☐ soft ☐ gas permeable Brand _____

Are the contact lenses that you are currently wearing comfortable? ☐ Yes ☐ No ☐ N/A

Are you interested in contact lenses? ☐ Yes ☐ No Color contacts? ☐ Yes ☐ No

Allergies _____ Ocular History _____

Medications _____ Injuries / Surgeries _____

_____ ☐ See Attached List _____ ☐ See over for additional info

Family Medical History: Note relation to yourself (ex: “mother” or “paternal grandfather” etc)

Welcome to our office!

☐ Blindness _____
☐ Cataracts _____
☐ Macular Degeneration _____
☐ Glaucoma _____
☐ Retinal Detachment _____
☐ Crossed Eyes _____
☐ Lupus
_____

☐ Cancer _____
☐ Diabetes
_____
☐ Heart Disease
_____
☐ High Blood Pressure
_____
☐ Kidney Disease
_____
☐ Arthritis
_____
☐ Thyroid Disease
_____

☐ Other _____
_____

Review of Systems. Please check all that apply to you.

Eyes
☐ Vision Loss
☐ Blurry Vision
☐ Distorted Vision
☐ Double Vision
☐ Dryness
☐ Redness
☐ Mucous Discharge
☐ Gritty Feeling
☐ Itching
☐ Burning
☐ Excess Watering
☐ Light Sensitivity
☐ Eye Pain/Soreness
☐ Chronic Infection
☐ Styes/Cysts
☐ Flashes
☐ Floaters/Spots
☐ Tired Eyes
☐ Cataracts
☐ Diabetic Retinopathy
☐ Glaucoma

Respiratory
☐ Asthma
☐ Bronchitis
☐ Emphysema

Constitutional
☐ Fever
☐ Weight Gain/Loss
☐ Fatigue
☐ Trauma

Integumentary/Skin
☐ Eczema
☐ Rosacea
☐ Psoriasis

Gastrointestinal
☐ Colitis
☐ Crohn's Disease
☐ Ulcers
☐ Constipation
☐ Diarrhea

Endocrine
☐ Non Insulin Diabetes
☐ Insulin Diabetes
☐ Thyroid Dysfunction
☐ Hormonal Dysfunction

Musculoskeletal
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Osteoarthritis
☐ Ankylosing Spondylitis

Lymphatic/Hematologic
☐ Anemia
☐ Bleeding Problems
☐ Leukemia

Ear / Nose / Throat
☐ Allergies
☐ Sinus Congestion
☐ Runny Nose
☐ Post Nasal Drip
☐ Chronic Cough

Allergic / Immune
☐ Drug Allergies
☐ Seasonal Allergies
☐ Lupus
☐ Arthritis

Neurologic
☐ Headaches
☐ Migraines
☐ Seizures
☐ Multiple Sclerosis

Cardiovascular
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol

Genitourinary
☐ Kidney Problems
☐ Incontinence
☐ STDs

☐ *Other* _____

Welcome to our office!

☐ Macular Degeneration
☐ Retinal Detachment

☐ Dry Throat/Mouth _____

☐ Currently pregnant or nursing

☐ Drive	☐ Don't Drive	Driving Difficulties _____
☐ Use Tobacco	☐ Don't Use Tobacco	Type/Amount/Frequency _____
☐ Drink Alcohol	☐ Don't Drink Alcohol	Type/Amount/Frequency _____
☐ Use Illegal Drugs	☐ Don't Use Illegal Drugs	Type/Amount/Frequency _____

Have you ever been infected with: ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV ☐ N/A