



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 _____



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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!

- | | |
|---|--|
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Retinal Detachment _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Crossed Eyes _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Lupus _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> 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 _____



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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