PATIENT INFORMATION

Last Name_____ First Name_____ M OR F Birth Date____/_____/___

Street_____ City _____ State_____ Zip _____

Home Phone_____ Work/Cell Phone _____

Referred By_____ E-mail Address _____

Employer_____ Occupation _____

INSURANCE INFORMATION

Flex Spending Account: Yes_____ No_____

Plan Name
_____ Single_____ Married_____ Widowed____

Insured Name
_____ Relationship to Member: Self____ Spouse____ Dependent____

Insured ID#
_____ Insured Date of Birth____/____/____ Insured SS# _____/_____/_____

OCULAR AND MEDICAL HISTORY

What is the reason for today's exam? _____

Have your eyes been dilated in the last 5 years? Yes____ No_____

Age of Present Glasses_____ Age of Sunglasses_____ Date of Last Eye Exam _____ Previous Doctor _____

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THESE CONDITIONS?

CONDITION	SELF	RELATIVE	NO		CONDITION	SELF	RELATIVE	NO
Diabetes	☐	☐	☐		Cataract	☐	☐	☐
Heart Disease	☐	☐	☐		Glaucoma	☐	☐	☐
Hypertension	☐	☐	☐		Amblyopia	☐	☐	☐
Cholesterol	☐	☐	☐		Blindness	☐	☐	☐
Inflammatory Disease	☐	☐	☐		Macular Degeneration	☐	☐	☐
Thyroid Disease	☐	☐	☐		Cancer	☐	☐	☐
Neurological	☐	☐	☐		Dermatologic	☐	☐	☐
Psychiatric	☐	☐	☐		Allergies	☐	☐	☐
Gastro Intestinal	☐	☐	☐		Lung Disease	☐	☐	☐

Present medications used:_____

Family Medical Doctor_____ Payment: Cash Check Charge Insurance

I give permission to submit my insurance claim._____ _____
Patients Signature Date

Do you wear glasses?	Yes	No		Are you planning to get new glasses today?	Yes	No
Do you wear contact lenses?	Yes	No		Do you need a contact lenses exam today?	Yes	No
What brand of contact lenses do you wear?						