Patient Demographic Information

Patient Information

Patient Name: _____ Preferred Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ May we send you text messages? Y N

Email: _____ (To receive appointment reminders, vision and health news and more, please update your email address. Your personal information is kept strictly confidential and never shared.)

Birth Date: _____ Social Security Number: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy: _____
City Zip

Patient Employment Information

Occupation: _____ Employer: _____

Address: _____
Street City State Zip

Parent/Guardian/Power of Attorney Information (must be filled out for patients under 18)

Guarantor Name: _____ Relationship to Patient: _____
Last First MI

Guarantor DOB: _____ Guarantor SSN: _____

Address: _____
Street City State Zip

Guarantor Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Insurance Information

Vision Insurance Name: _____ ID #: _____ Group #: _____

Medical Insurance Name: _____ ID #: _____ Group #: _____

Insurance policy holder: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Insured SSN: _____

Name of Insured: _____ Insured DOB: _____
Last First MI

Insured Address: _____
Street City State Zip

Insured Phone: _____ Insured Employer: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Release and Assignment

I authorize the release of any information necessary to process my insurance claims and assign and request payment to my physicians. I understand that eligibility and/or benefits cannot be guaranteed, therefore all outstanding balances left after insurance reimbursement are my responsibility including collection and attorney fees.

Signature: _____ Date: _____

All eyeglass and contact lens prescriptions expire one year from exam date unless otherwise specified.

Patient History and Review of Systems

Patient Name: _____ DOB: _____/_____/_____

Height: _____ Weight: _____ Race: _____

What do you currently wear? Circle all that apply Eyeglasses Contact Lenses No correction

Please circle if *you* have a history of any of the following *medical* conditions:

Asthma	Diabetes	Hepatitis	HIV/AIDS	Hyperthyroid	Stroke
COPD	End stage renal disease	High blood pressure	High Cholesterol	Hypothyroid	None

Please list any past surgeries: _____

Please circle if *you* have a history of any of the following *eye* conditions:

Cataracts	Dry eyes	Macular degeneration	Strabismus	Floaters
Diabetic retinopathy	Glaucoma/suspect	Retinal tear/detachment	Vitreous detachment	None

Please list any *eye* surgeries or injuries: _____

Do you take any medications? Yes No **Please list *all* medications and dosages:** _____

_____

_____

Are you allergic to any medication? Yes No **If yes, please list the medication *and* give the reaction:**

_____

Do you smoke? Yes No **If yes, how often do you smoke?** Daily Some days

Do you use recreational drugs? Yes No **Do you use IV drugs?** Yes No

How often do you drink alcohol? None less than 1 drink/day 1-2 drinks/day 3 or more drinks/day

Do you feel safe at home? Yes No

Do you drive your car? Daytime only Drive night and day Do not drive

How often do you exercise? Several times/day once/day a few times/week a few times/month never

What is your caffeine use? Several times/day once/day a few times/week a few times/month never

Family History: Check all that apply *and* list the family member(s):

Diabetes_____	Heart disease_____	Macular Degeneration_____
Hypertension_____	Glaucoma_____	Retinal Detachment_____

Please circle if YOU have any of the following:

Poor vision	Diabetes Type 2	Amaurosis fugax	Upset stomach	Seizure
Vision loss	Diabetes Type 1	Fever	Diarrhea	Stroke
Floaters	High blood pressure	Chills	Constipation	Paralysis
Flashes of light	Asthma/COPD	Weight loss	Burning on urination	Anxiety/Depression
Eye surgery/injury	Wheezing	Stuffy nose	Urinary frequency	Insomnia
Glaucoma	Shortness of breath	Ear ache	Incontinence	Thyroid abnormality
Eye pain	Kidney disease/failure	Cough	Joint pain/stiffness	Bleeding
Tearing	Allergies	Dry mouth	Arthritis	Anemia
Redness	Jaw pain	Rapid heart beat	Rash	Hay fever
Headache	Scalp tenderness	Congestion	Changing moles	Hives

Please circle if YOU have any of the following alerts:

Allergy to latex	Artificial joints	MRSA	Rapid heartbeat with epinephrine
Allergy to adhesive	Blood thinners	Narrow angles	Pregnancy or planning pregnancy
Allergy to lidocaine	Defibrillator	Pacemaker	Pseudoexfoliation Syndrome
Artificial heart valve	Flomax	Premedication (prior to procedures)	Steroid responder