

Full Legal Name _____ Nickname _____

Address _____ Mr Mrs Ms Miss Dr _____

City/State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell _____

Occupation _____ Birth date _____ Email _____

Whom may we send a thank you to for your referral? _____

or did you find out about us through: **Location Sign Insurance Phone Book Internet Search**

List the names of any immediate family members who are patients here:

Who is responsible for payment? _____

Do you have: Vision Insurance _____

Medical Insurance _____

Medicare _____ Secondary _____

Medical and Eye History

When was your last eye exam? _____ Do you wear: **Glasses Contacts Neither**

Are you interested in: **Contact Lenses Laser Vision Correction Sunglasses Computer Glasses**

Do you have: **Diabetes High Blood Pressure Heart Disease Asthma Thyroid Disease**

Other health conditions: _____

List your medications: _____

Do you use any eye drops? _____ Please list: _____

Are you allergic to any medication? **Yes No** Please list: _____

Have you ever had: **Eye Injury Eye Surgery Eye Disease Cataracts Glaucoma Macular Degeneration**

Does anyone related to you have: **Diabetes High Blood Pressure Glaucoma Macular Degeneration**

