(Mrs/Ms/Mr/Dr) Name: ____ Gender: ❑ Male ❑ Female

Date of Birth: ____________________ Social Security Number: ______-______-______

Address: ___________________________ City: _________________ State: _____ Zip: _______

Phone: (C/H) _________________________ E-mail: __________________________________

How Did You Hear About Us? ______________________ Last Eye Exam: _____________________

Primary Care Physician: _______________________ Occupation: __________________________

Emergency Contact & Phone: ____

PERSONAL AND FAMILY MEDICAL/EYE HISTORY

Do you or any member of your family have, or have had, any problems in the following areas?

	ME		FAMILY			ME		FAMILY	
DIABETES:	YES	NO	YES	NO	MIGRAINE:	YES	NO	YES	NO
HIGH BLOOD PRESSURE:	YES	NO	YES	NO	RETINAL PROBLEMS:	YES	NO	YES	NO
HEART PROBLEMS:	YES	NO	YES	NO	HIV/AIDS:	YES	NO	YES	NO
CHOLESTEROL:	YES	NO	YES	NO	ALLERGIES:	YES	NO	YES	NO
CANCER:	YES	NO	YES	NO	LAZY EYE:	YES	NO	YES	NO
ARTHRITIS:	YES	NO	YES	NO	GLAUCOMA:	YES	NO	YES	NO
THYROID:	YES	NO	YES	NO	MACULAR DEGENERATION:	YES	NO	YES	NO
STD/STI:	YES	NO			CATARACTS:	YES	NO	YES	NO
DO YOU SMOKE?	YES	NO			ARE YOU PREGNANT?	YES	NO		
HISTORY OF ALCOHOL ABUSE?	YES	NO			HISTORY OF SUBSTANCE ABUSE:	YES	NO		

PLEASE SEE BACK PAGE →

Please list all medication(s) that you are currently taking:

❑ None ____

____

Please list allergies to all prescription, non-prescription medications and what happens:

❑ None ____

____

PERSONAL EYE HISTORY

Have you had any previous eye surgery? ❑ Y ❑ N If yes, which eye(s) and type: ______________________

Have you had any previous eye injuries? ❑ Y ❑ N If yes, which eye(s) and type: ______________________

If you had your eyes dilated before, did you have an adverse reaction to the dilating eye drops? ❑ Y ❑ N

Reason(s) for Today's Examination:

____

Do you currently wear eyeglasses? ❑ Y ❑ N

If yes, for what distance(s): ❑ Distance ❑ Close-Up ❑ Distance and Close-Up

Do you currently wear contact lenses? ❑ Y ❑ N

If yes, please check all that apply below:

❑ Soft ❑ Rigid Gas-Permeable ❑ One Day ❑ Astigmatism ❑ Bifocal ❑ Overnight

Contact Solution Used: ____

ATTESTATION

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider. If my account becomes delinquent and is referred to an attorney or collection agency for collections, then I agree to pay a 30% attorney or collection fee on the unpaid balance.

______________________________ ______________________

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**