PATIENT INFORMATION

Last Name___________________________ First Name______________________ □M □F DOB___/_____/_____

Adress___________________________________ City________________Apt ______ State_______ Zip _________

Home Phone(____)_____________Work Phone(____)____________ Cell Phone(____)_______________________

Employer ____ Occupation________________________________

Reffered By ____________________ Email Address ______________________ Signature____________________

INSURANCE INFORMATION

Plan Name ___________________________________Vision Provider _________________________________

Insured Name ________________________________ Insured Date of Birth ___/_____/_____ □M □F

Insured ID# or SS#_____________________ Relationship to Patient: □ Self □ Spouse □ Child (check one)

PLEASE BE ADVISED, INSURANCE ORDERS CAN TAKE FROM 10-15 BUSINESS DAYS. WE WILL CALL YOU ONCE WE RECEIVE YOUR ORDER.

OCULAR AND MEDICAL HISTORY

What is the primary reason for today's visit? ____

Age of present glasses ______ Age of sunglasses ________ Date of last exam ____/______/______ Previous DR. _________________ Previous patient? YES NO

Do you or any of your blood relatives (I.E. GRANDPARENTS, PARENTS, BROTHER, OR SISTER) have any of these conditions?

	Self	relative		Self	Relative		YES	NO
Diabetes			Glaucoma	□	□	Do you see double?	□	□
High Blood Pressure	□	□	Cataracts	□	□	Frequent headaches?	□	□
Thyroid Problems	□	□	Retinal Disease	□	□	Bright lights bother you?	□	□
Heart Disease	□	□	Eye Surgery	□	□	Are you pregnant?	□	□
Asthma	□	□	Eye Injury	□	□	Eyes been dilated?	□	□
Cancer	□	□	Other__________________			Primary care DR.____________________		

Please explain any positive findings?____

Are you taking any eye drops (prescription or over the counter)? Please List________________________________

Are you taking any other medications (prescription or over the counter)? Please List___________________________

Do you have any allergies, medication or other? if yes, please explain____

Do you use cigarettes/tobacco?__________________________________Alcohol?____

CONTACT LENS INFORMATION

Do you wear contact lenses now? YES NO IF YES, WHAT TYPE?________________________

Have you ever worn contact lenses? YES NO IF YES, WHAT TYPE?________________________

Are you interested in updating your current contact lens prescription? YES NO

(An annual renewed prescription is necessary for reordering contact lenses)

SPECIAL TASK INFORMATION

Do you participate in any of the following: (check all that apply)

□ Night Driving
□ Fine,Detailed work(sewing/needlepoint)
□ Extended Reading
□ Computer Use. If so, how many hrs?
□ Home Repair/ Yard work

SUN AND SPORT INFORMATION

How many hrs a day are you in the sun?__________________

Do you wear sunglasses while outside?_____

Do you participate in any sports? If so, please list____________________________________