

Date \_\_\_\_\_

**Patients Name** \_\_\_\_\_

 Mr  Mrs  Dr  
 Miss  Ms  Rev

How did you hear about Eye Services? \_\_\_\_\_

Date of Last Vision Exam \_\_\_\_\_ With Whom \_\_\_\_\_

Briefly explain the reason for your visit \_\_\_\_\_

 Do You Wear Eye Glasses?  Yes  No

 Are You Interested in Glasses?  Yes  No Type of Lenses \_\_\_\_\_

 Do You Wear Contact Lenses?  Yes  No Type of Lenses \_\_\_\_\_

 Are You Interested in Contact Lenses?  Yes  No Type of Lenses \_\_\_\_\_

 Are you interested in surgery to reduce or eliminate your dependency on glasses and/or contact lenses?  Yes  No

**Please answer the Health Questions below by checking either Yes or No**

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Abnormalities	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	TB/Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung/Asthma Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis TB/Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant (Currently)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Tendencies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		

List any current medications \_\_\_\_\_

Eye Drops \_\_\_\_\_

List any allergies to medications \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**Family History**

Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus (lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you had any eye injuries or eye surgeries? If yes please explain \_\_\_\_\_

Have you had any general surgeries? If yes please explain \_\_\_\_\_

**Have you ever been diagnosed with any of the following**

Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus (lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Serious Eye Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Insurance Information**

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Patients Name \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Texting  Yes  No

Patient Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Occupation \_\_\_\_\_  
Name of Employer \_\_\_\_\_  
Special Visual Demands (Work or Hobbies) \_\_\_\_\_

Do You Have Vision Insurance  Yes  No  
Do You Have Medical Insurance  Yes  No

**Primary**

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Primary Vision Insurance \_\_\_\_\_  
Medical Insurance \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Policy Holder D.O.B. \_\_\_\_\_  
Relationship to Policy Holder \_\_\_\_\_  
Policy Holder Social Security \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer of Policy Holder \_\_\_\_\_

**Secondary**

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Second Vision Insurance \_\_\_\_\_  
Second Medical Insurance \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Policy Holder D.O.B. \_\_\_\_\_  
Relationship to Policy Holder \_\_\_\_\_  
Policy Holder Social Security \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer of Policy Holder \_\_\_\_\_

**In Case of Emergency**

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Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

**Please Sign**

I authorize the release of any medical information necessary to process insurance claims and request payment to either myself or the party who accepts assignment. I state that the information on this document is correct to the best of my knowledge. I permit a copy of these benefits to myself or the party who accepts assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_