Welcome To Our Office! **Image Eye Care – Drs. Todd and Holly Hamilton**

Patient Information:

Last name _____ **First name** _____ **MI** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Birthdate _____ **Sex:** ❑ **M** ❑ **F** **SSN** _____ **Marital Status** _____

Cell Phone _____ **Texting OK (Non-Marketing)?** ❑ **Yes** ❑ **No** **Home Phone** _____

Email Address _____ **Referred By** _____

Occupation _____ **Employer** _____

Communication Preference: ❑ **Text to Cell Phone** ❑ **Call to Cell Phone** ❑ **Email** ❑ **Home Phone** ❑ **Work Phone** ❑ **Postal Mail**

REVIEW OF SYSTEMS: **Do you have health problems with any of these systems? Please check all that apply.**

❑ **Allergy**	❑ **Gastrointestinal**	❑ **Immunologic**	❑ **Neurological**
❑ **Cardiovascular (Heart)**	❑ **Ear, Nose, Mouth, Throat**	❑ **Skin**	❑ **Psychiatric**
❑ **Endocrine (Diabetes, Thyroid)**	❑ **Blood/Lymphatic**	❑ **Musculoskeletal**	❑ **Respiratory**

Please explain: _____
_____

MEDICAL HISTORY: **Name of Primary Physician** _____
Current Medications _____
Medication Allergies _____
Current Medical Conditions _____
_____
Any major surgeries? Please explain _____

Do you use: ❑ **Tobacco** ❑ **Alcohol** ❑ **Recreational Drugs**

Race*: ❑ **White** ❑ **African American** ❑ **Hispanic** ❑ **Native American** ❑ **Asian** ❑ **Other** **(*Response Optional)**

Ethnicity*: ❑ **Hispanic** ❑ **Non-Hispanic** ❑ **Pacific Islander** **Preferred Language*:** _____

FAMILY MEDICAL HISTORY: **Has anyone in your family had the following conditions? If so, please indicate who.**

❑ **Diabetes**	_____	❑ **Rheumatoid Arthritis**	_____	❑ **Keratoconus**	_____
❑ **Hypertension**	_____	❑ **Glaucoma**	_____	❑ **Colorblindness**	_____
❑ **High Cholesterol**	_____	❑ **Macular Degeneration**	_____	❑ **Lazy/Turned Eye**	_____
❑ **Heart Disease**	_____	**Other Condition:**	_____		

OCULAR HISTORY: **Date of Last Eye Exam** _____ **By Dr.** _____
Have you had any eye surgeries? ❑ **Yes** ❑ **No** **Type and Year:** _____
Have you had any eye injuries? ❑ **Yes** ❑ **No** **Type and Year:** _____

Do you have:	❑ **Glaucoma**	❑ **Keratoconus**	❑ **Near Vision Blur**	❑ **Double Vision**	❑ **Watery Eyes**
	❑ **Cataracts**	❑ **Amblyopia**	❑ **Distance Blur**	❑ **Floaters**	❑ **Itchy Eyes**
	❑ **Macular Degeneration**	❑ **Strabismus**	❑ **Middle Vision Blur**	❑ **Flashes of Light**	❑ **Dry Eyes**
	❑ **Colorblindness**	❑ **Double Vision**	❑ **Headaches**	❑ **Halos/Glare**	❑ **Red Eyes**

Do you currently wear glasses? ❑ **Yes** ❑ **No** **Do you currently wear contact lenses?** ❑ **Yes** ❑ **No** **What kind?** _____
What is the reason for today's visit? _____
Are you having any eye problems? _____

Signature _____ **Date** _____

Insurance Subscriber Information

(To be filled out ONLY if primary subscriber is not the patient)

Vision Insurance	Medical Insurance
Insurance Name:	**Insurance Name:**
_____	_____
Subscriber Name:	**Subscriber Name:**
_____	_____
Subscriber Date of Birth:	**Subscriber Date of Birth:**
_____	_____
Subscriber Address:	**Subscriber Address:**
_____	_____
_____	_____
Subscriber Phone Number:	**Subscriber Phone Number:**
_____	_____
Subscriber SSN:	**Subscriber SSN:**
_____	_____
Subscriber's Employer:	**Subscriber's Employer:**
_____	_____
Patient's Relationship to Subscriber:	**Patient's Relationship to Subscriber:**
_____	_____