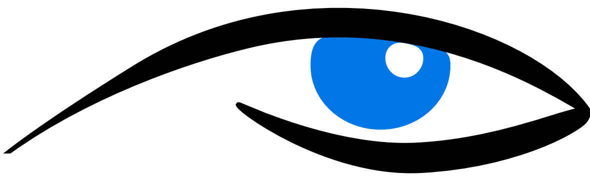

Enid Vision Center

Today's Date: ____________________

Personal Information

Last Name | First Name | MI

Address | City | State | Zip

Birthday | Age | SSN

Insurance Information

Vision Insurance | **Subscriber's Name**

Subscriber's SSN | **Subscriber's DOB** | **Subscriber's Employer**

Medical Insurance | **Subscriber's Name**

Subscriber's SSN | **Subscriber's DOB** | **Subscriber's Name**

Health History

Reason for today's visit: ______________________________

Are you interested in new glasses or contact lenses today: (Check one)

❑ Glasses ❑ Contacts ❑ Both ❑ Lasik

Current eye symptoms/conditions

- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Dryness
- ❑ Light Sensitivity
- ❑ Burning
- ❑ Itching
- ❑ Tearing
- ❑ Redness
- ❑ Flashes of Light
- ❑ Floaters
- ❑ Eye Pain
- ❑ Unexplained Headaches

Ocular History

- ❑ Cataracts
- ❑ Amblyopia/Lazy Eye
- ❑ Strabismus/Crossed Eye
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retinal Problems
- ❑ Eye Infection
- ❑ Eye Surgery
- ❑ Eye Trauma

Other: ______________________________

Medical History

Name of Physician: ____________________ Date of Last Exam ________

Are you Pregnant ❑ Yes ❑ No

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Thyroid Problem
- ❑ Anxiety/Depression
- ❑ Hepatitis
- ❑ Respiratory Problems
- ❑ Stroke/Neurological
- ❑ Cardio Vascular Problems
- ❑ Blood Clot/Bleeding
- ❑ Sickle Cell Anemia
- ❑ Tuberculosis
- ❑ Cancer
- ❑ Kidney Problems
- ❑ Skin Disorders
- ❑ HIV/Aids
- ❑ Arthritis

Other: ______________________________

Family History

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Blindness
- ❑ Glaucoma
- ❑ Amblyopia/Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Strabismus/Crossed Eyes
- ❑ Eye Trauma

Contact Information

Home Phone: ____________________

Work Phone: ____________________

Cell Phone: ____________________

Email: ____________________

What is the best way for us to reach you?

❑ Home ❑ Work ❑ Cell ❑ Email

How do you plan to settle your account today?

❑ Cash ❑ Check ❑ Credit

❑ Flex Spending Account

Social History

Employer: ____________________

Use of Alcohol: __ None __ Social __ Frequent

Use of Tobacco: __ None __ Former Smoker

__ Smoker __ Smokeless

Use of Narcotics: __ None

Type & Frequency: ____________________

Medications

1. ____________________

2. ____________________

3. ____________________

4. ____________________

5. ____________________

6. ____________________

Medication Allergies

1. ____________________

2. ____________________

3. ____________________

4. ____________________