Patient Information Form

Date_____Last Name_____First Name_____

Address: Street_____

City_____State_____Zip_____

Occupation_____Hobbies_____

Sex: M or F Date of birth___/___/_____Email address_____

Phone: work_____home_____cell_____

Parent or guardian if under 18 yrs of age_____

I am a___new, or ___previous patient. Referred by_____

Reason For Today's Visit:
___Annual exam___Glasses___Contacts___Eye infection___Lasik___Medical problem
___Other_____
_____

Eye History, Please Check All That Apply:
___Blurred Vision at near ___Blurred vision at far ___Headaches ___Droopy eyelid
___Floaters and flashes ___Sudden vision loss ___Color blind ___Macular degeneration
___Lazy eye ___Distorted vision ___Dry eye ___Eye pain
___Tired eyes ___Redness ___Itchy eyes ___Glaucoma
___Foreign Body ___Cataracts ___Burning ___Mucous discharge
___Other_____

Previous eye surgeries_____

Family history of eye diseases_____

Current medications_____

Drug allergies_____

Vision Insurance Information
Insurance Co._____Policy#_____Group#_____

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Office Use Only:
Patient Type: New ex, Previous ex,New ex CL, Previous ex CL
Diagn: Myopia367.1, Hyperopia367.0, Astig 367.20, Presbyopia367.4, Cataracts366.9, Other