RYE EYE CARE

New Patient Form

PERSONAL INFORMATION

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone(Home) _____ (Business) _____ Occupation _____

Phone(Cell) _____

Spouse Name _____ DOB _____ Children's names: _____

Email Address _____

Facebook _____ Instagram _____

HOW WERE YOU REFERRED TO OUR OFFICE TODAY?

☐ Established Patient
☐ Walk In
☐ Insurance Company
☐ Rye Eye Care Website
☐ Yelp Review or Google Review(Please Circle One)
☐ Friend or Family Member, if so who? _____
☐ Local Merchant or Local Employee? _____
☐ Other _____

INSURANCE INFORMATION

Person responsible for account _____ DOB _____

Relationship to Patient _____ Last 4 # of Social Security _____

Medical Insurance Company _____

Vision Insurance Company _____

EYE HISTORY

Date of last eye exam _____ Date of last eyeglasses _____

Do you have any of the following:

☐ Y ☐ N Blurry vision-distance	☐ Y ☐ N Tearing	☐ Y ☐ N Difficulty at computer
☐ Y ☐ N Blurry vision-near	☐ Y ☐ N Dry Eyes	☐ Y ☐ N Eye pain
☐ Y ☐ N Redness	☐ Y ☐ N Headaches	☐ Y ☐ N Floaters
☐ Y ☐ N Burning	☐ Y ☐ N Double Vision	☐ Y ☐ N Cataracts
☐ Y ☐ N Itching	☐ Y ☐ N Light sensitivity	☐ Y ☐ N Glaucoma

Have you had any eye operations/eye injuries? _____

Do you use eye drops? Please list _____

RYE EYE CARE

New Patient Form(continued)

CONTACT LENSES

Do you presently wear contact lenses? _____ If not, would you be interested? _____

Type of lens (Circle ONE) I. Soft 2. Hard 3. Extended Wear 4. Toric 5. Multifocal

Brand _____ Prescription_____ R:_____ L:_____ BC Diameter _____

How many hours per day do you wear your lenses? _____

How often do you dispose of your lenses? _____ How old is your current pair of lenses? _____

What brand(s) of solution do you use to care for your lenses? _____

MEDICAL HISTORY

Last Medical Exam _____ Name of Physician _____

Are you currently pregnant? ☐ Y ☐ N

Do you have any problems with any of the following? (Please Circle)

Immunologic (multiple sclerosis, lupus)	☐ Y ☐ N	Cardiovascular (high BP)	☐ Y ☐ N
Ear/Nose/Throat/Mouth (sinusitis)	☐ Y ☐ N	Endocrine (diabetes, thyroid)	☐ Y ☐ N
Gastrointestinal (ulcers, liver)	☐ Y ☐ N	Neurological (stroke, seizure)	☐ Y ☐ N
Integumentary (skin disorders)	☐ Y ☐ N	Respiratory (asthma, breathing)	☐ Y ☐ N
Genitourinary (prostate, kidney)	☐ Y ☐ N	Psychological (anxiety, depression)	☐ Y ☐ N
Hematologic (cholesterol)	☐ Y ☐ N	Musculoskeletal (arthritis)	☐ Y ☐ N
Cancer (breast, lymphoma)	☐ Y ☐ N	Other _____	

Do you have any allergies? _____ **Please list** _____

Do you use tobacco? _____ If yes, how many packs per day? _____

Do you consume alcoholic beverages? _____ If yes, how many drinks per week? _____

Please list any medications that you are presently taking (prescription, non-prescription, vitamins and supplements) _____

_____

FAMILY HISTORY(If so, please list relation)

High Blood Pressure	☐ Y ☐ N _____	Cataracts	☐ Y ☐ N _____
Diabetes	☐ Y ☐ N _____	Retinal Detachment	☐ Y ☐ N _____
Glaucoma	☐ Y ☐ N _____	Blindness	☐ Y ☐ N _____
Macular Degeneration	☐ Y ☐ N _____		

Patient signature _____ **Today's Date** _____