LANTANA EYECARE
Welcome to our office

Date _____

Last Name _____ First Name _____ MI _____

Preferred Name _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Date of Birth _____ Occupation _____ Email _____

Emergency Contact Name _____ Phone Number _____

Date of Last Eye Exam _____ Referred By _____

Primary Vision Coverage _____

Policy Holder's Name _____

Policy Holder's SS# _____ Policy Holder's DOB _____

Medical Information

How is your general health? _____

Do you take any medications for any of these symptoms? (Please circle yes or no.)

Gastrointestinal	Y / N	Nervous	Y / N	Endocrine (glands)	Y / N
Ears/Nose/Throat	Y / N	Urinary	Y / N	Blood/Lymph	Y / N
Cardiovascular	Y / N	Muscles/Bones	Y / N	Allergic/Immunologic	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Headaches	Y / N
High Blood Pressure	Y / N	Eyes	Y / N	Mental	Y / N

Please explain _____

Diabetes Y / N _____ Type _____ Date of diagnosis _____

Allergies to medication Y / N Which? _____ Reactions? _____

Other health concerns _____

Current medication(s) _____

Have you had any operations Y / N Kind? _____ When? _____

Name of family doctor and/or primary care physician _____

Date of last physical _____

Family History

High blood pressure	Y / N	Relation	_____	Macular degeneration	Y / N	Relation	_____
Diabetes	Y / N	Relation	_____	Retinal detachment	Y / N	Relation	_____
Glaucoma	Y / N	Relation	_____	Cataracts	Y / N	Relation	_____

Personal Eye Information

Do you have any eye conditions or concerns? Y / N What kind? _____

Have you had any eye operations? Y / N Type _____

Have you had an eye injury? Y / N Kind _____

Do you have glaucoma?	Y / N	Cataracts?	Y / N	Dry Eye?	Y / N
Macular degeneration?	Y / N	Retinal Detachment?	Y / N	Blurred vision?	Y / N
Do you wear glasses?	Y / N	Contact lenses?	Y / N	Type	_____

Additional Information _____

Fundus Evaluation

Optos $39 _____ Dilation _____ Decline Optos and Dilation _____

Yearly Update

Reviewed by _____	Optos $39 ____	Dilation ____	Decline Optos and Dilation ____	Date _____
Reviewed by _____	Optos $39 ____	Dilation ____	Decline Optos and Dilation ____	Date _____
Reviewed by _____	Optos $39 ____	Dilation ____	Decline Optos and Dilation ____	Date _____
Reviewed by _____	Optos $39 ____	Dilation ____	Decline Optos and Dilation ____	Date _____

FLOWER MOUND EYE CARE
Welcome to our office

Date _____

Last Name _____ First Name _____ MI _____

Preferred Name _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Date of Birth _____ Occupation _____ Email _____

Emergency Contact Name _____ Phone Number _____

Date of Last Eye Exam _____ Referred By _____

Primary Vision Coverage _____

Policy Holder's Name _____

Policy Holder's SS# _____ Policy Holder's DOB _____

Medical Information

How is your general health? _____

Do you take any medications for any of these symptoms? (Please circle yes or no.)

Gastrointestinal	Y / N	Nervous	Y / N	Endocrine (glands)	Y / N	Respiratory	Y / N
Ears/Nose/Throat	Y / N	Urinary	Y / N	Blood/Lymph	Y / N	Headaches	Y / N
Cardiovascular	Y / N	Muscles/Bones	Y / N	Allergic/Immunologic	Y / N	Mental	Y / N
High Blood Pressure	Y / N	Integumentary (skin)	Y / N				

Please explain _____

Diabetes Y / N _____ Type _____ Date of diagnosis _____

Allergies to medication Y / N Which? _____ Reactions? _____

Other health concerns _____

Current medication(s) _____

Have you had any operations Y / N Kind? _____ When? _____

Name of family doctor and/or primary care physician _____

Date of last physical _____

Family History

High blood pressure	Y / N	Relation	_____	Macular degeneration	Y / N	Relation	_____
Diabetes	Y / N	Relation	_____	Retinal detachment	Y / N	Relation	_____
Glaucoma	Y / N	Relation	_____	Cataracts	Y / N	Relation	_____

Personal Eye Information

Do you have any eye conditions or concerns? Y / N What kind? _____

Have you had any eye operations? Y / N Type _____

Have you had an eye injury? Y / N Kind _____

Do you have glaucoma?	Y / N	Cataracts?	Y / N	Dry Eye?	Y / N
Macular degeneration?	Y / N	Retinal Detachment?	Y / N	Blurred vision?	Y / N
Do you wear glasses?	Y / N	Contact lenses?	Y / N	Type	_____

Rx Eye Drops/ OTC Eye Drops or other additional information _____

Fundus Evaluation

Optos $39 _____ Dilation _____ Decline Optos and Dilation _____

Yearly Update

Reviewed by _____ Optos $39 _____ Dilation _____ Decline Optos and Dilation _____ Date _____

Reviewed by _____ Optos $39 _____ Dilation _____ Decline Optos and Dilation _____ Date _____

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Reviewed by _____ Optos $39 _____ Dilation _____ Decline Optos and Dilation _____ Date _____