LANTANA EYECARE Welcome to our office

Last Name	Date					
Last Name	First Name			MI		
Preferred NameAddress	Q1.					
	_ City		State	Zip		
Date of Birth Occupation	Home Phone					
Emergency Contact Name	Email					
Emergency Contact Name	D of owned 1	P.	hone Number			
Date of Last Eye Exam Primary Vision Coverage	Referred	ву				
Primary Vision Coverage Policy Holder's Name						
Policy Holder's SS#		Policy Holder's D	OR			
Medical Information		roney florder 3 D	ОВ			
How is your general health?						
Do you take any medications for any of these	e symptoms? (P	lease circle ves	or no)			
Gastrointestinal Y/N Nervo		Y/N	entros tilli	anda) X/AI		
Ears/Nose/Throat Y/N Urinar		Y/N	Endocrine (gla			
C II	es/Bones		Blood/Lymph	Y/N		
		Y/N	Allergic/Immu	ě .		
II' 1 D1 1 1 D	mentary (skin)		Headaches	Y/N		
,		Y/N	Mental	Y/N		
Please explain						
Allergies to modication V / N. Whish 9	e	Date of diagnosis				
Allergies to medication Y / N Which?		Reaction	ıs?			
Other health concerns						
Current medication(s)						
Have you had any operations Y / N Kind?			When?			
Name of family doctor and/or primary care phy	sician	-				
Date of last physical						
Family History						
High blood pressure Y/N Relation		lacular degenera	tion Y/N	Relation		
Diabetes Y/N Relation	R	Retinal detachment		Relation		
Glaucoma Y/N Relation	C	ataracts	Y/N	Relation		
Personal Eye Information						
Do you have any eye conditions or concerns?	Y/N What I	kind?				
**) 				
Have you had an eye injury? Y/N	Kind					
Do you have glaucoma? Y/N	_			0 ***/>*		
Macular degeneration? Y/N	Cataracts?	Y / N	Dry Fy	(A)		
	Cataracts? Retinal Detach	Y/N ment? Y/N	5 -5	2 2 22 23 23 23 23 25 25 25 25 25 25 25 25 25 25 25 25 25		
Do you wear glasses? Y / N	Retinal Detach	ment? Y/N	Blurred	l vision? Y/N		
	Retinal Detach Contact lenses	ment? Y/N? Y/N	Blurred	2 2 22 23 23 23 23 25 25 25 25 25 25 25 25 25 25 25 25 25		
Additional Information	Retinal Detach Contact lenses	ment? Y/N? Y/N	Blurred	l vision? Y/N		
Additional Information Fundus Evaluation	Retinal Detach Contact lenses	ment? Y/N? Y/N	Blurred Type	l vision? Y/N		
Additional Information Fundus Evaluation Dilation	Retinal Detach Contact lenses	ment? Y/N? Y/N	Blurred Type	l vision? Y/N		
Additional Information Fundus Evaluation Optos \$39 Dilation Yearly Update	Retinal Detach Contact lenses	ment? Y/N? Y/N Decl	Blurred Type _ ine Optos and Dil	l vision? Y/N		
Additional Information	Retinal Detach Contact lenses	ment? Y/N? Y/N Decl	Blurred Type ine Optos and Dil Optos and Dilation	ation Date		
Additional Information Fundus Evaluation Optos \$39 Dilation Yearly Update	Retinal Detach Contact lenses 339 Dilation 339 Dilation	ment? Y/N? Y/N Decl Decline Decline	Blurred Type _ ine Optos and Dil	ation Date Date		

FLOWER MOUND EYE CARE Welcome to our office

ast Name First Name				me	MI			
Preferred Name								
Address			City	City		Zip		
Cell Phone				ome Phone				
				Email				
				Phone Number				
				erred By				
Policy Holder's Name								
Policy Holder's SS# _			Policy F	Holder's DOB				
Medical Information								
How is your general h	ealth? _							
Do you take any med	ications	for any of these syn	nptoms? (Pl	ease 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 (ski	n) Y/N					
Please explain								
Diabetes Y / N		Туре		Date or	f diagnos	is		
				Reactions?				
Other health concerns								
Current medication(s)								
Have you had any ope	erations Y	//N Kind?		Whe	n?			
Name of family docto	r and/or j	primary care physicia	an					
					3			
Family History								
High blood pressure	Y/N	Relation	M	facular degeneration	Y/N	Relation		
Diabetes	Y/N	Relation				Relation		
Glaucoma	Y/N	Relation		ataracts	Y/N	Relation		
Personal Eye Inform	ation							
Do you have any eye	conditior	s or concerns? Y/	N What l	kind?				
Have you had any eye	e operatio	ons? Y/1						
Have you had an eye	injury?	Y/N						
Do you have glaucom		Y/N Ca	ataracts?	Y/N	Dry Ey		Y/N	
Macular degeneration		Y/N Re	etinal Detach	nment? Y/N		d vision?	Y/N	
Do you wear glasses?			ontact lenses					
Fundus Evaluation								
Optos \$39 Dilation		7	Decline Opto	Decline Optos and Dilation				
Yearly Update								
Reviewed by		Optos \$39	Dilatio	n Decline Optos	and Dilat	ion Date		
Reviewed by			Dilatio					
Reviewed by			Dilatio	-		-		
Reviewed by		Optos \$39	Dilatio					