Welcome to BAYSIDE FAMILY EYECARE!

Name _____Date of Birth_____

Street_____City_____ State_____Zip Code _____

Home Phone_____ Cell Phone _____Work Phone _____

Email_____ Occupation_____

Have you ever been examined in our office before? ☐ Yes ☐ No

Do you presently wear: ☐ Glasses ☐ Contacts ☐ Both

What are you interested in a prescription for? ☐ Glasses ☐ Contacts ☐ Both

How much time to you spend on the computer daily? ☐ 2 hours or less ☐ 2-4 hours ☐ 5 hours or more

Please check any of the following activities you participate in.

☐ Golfing ☐ Skiing ☐ Fishing/Boating ☐ Swimming ☐ Basketball

Personal Medical History

Please check any of the following that apply to you.

☐ High Blood Pressure	☐ Allergies	☐ Glaucoma
☐ Diabetes	☐ Asthma	☐ Cataracts
☐ Heart Disease	☐ Thyroid Disease	☐ Lazy Eye
☐ Macular Degeneration	☐ Eye Injury	☐ Other _____
☐ Smoke	☐ Alcohol use	

Please list all medications you are taking:_____

Please list any medications you are allergic to:_____

Family History

☐ High Blood Pressure	☐ Allergies	☐ Glaucoma
☐ Diabetes	☐ Asthma	☐ Cataracts
☐ Heart Disease	☐ Thyroid Disease	☐ Lazy Eye
☐ Macular Degeneration	☐ Other_____	

Vision Insurance: _____ Insured ID# _____

Medical Insurance: _____ Insured ID# _____

Primary Insurance Holders Name _____ DOB _____/_____/_____

SS# _____ Relationship to patient: SELF SPOUSE PARENT

Plan Name _____ Group _____

I authorize the release of any medical or other information necessary in order to process insurance claims pertaining to my care in this office. I understand that I am responsible or the payment of any services not covered by my insurance plan, any additional charges specified by my plan, or any payment erroneously sent directly to me rather than to Bayside Family Eyecare. I also acknowledge that I was given a copy of Bayside Family Eyecare's Notice of Privacy Practices to read.

Signature _____ Date_____