ACQUAINTANCE FORM AND MEDICAL HISTORY

Dr.___
Mr. __
Mrs.__

LAST NAME_____ FIRST_____ MI____ Miss _

I PREFERRED TO BE CALLED_____

ADDRESS_____CITY_____ST____ ZIP_____

HOME PHONE_____WORK_____CELL_____

EMAIL ADDRESS_____PHYSICIAN_____

REFERRED BY_____ SPOUSE NAME _____

BIRTH DATE_____ AGE_____ SEX_____SSN#_____

VISION INS. _____ MEDICAL INS_____

EMPLOYER _____ OCCUPATION _____

PARENT'S NAME/D.O.B. Please print(if under 18)_____

I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical and/or vision benefits to Eason Eye Care. I understand I am responsible for payment of any services or materials not paid for by insurance including deductibles, co-pays, and non-covered services. **FLEXIBLE SPENDING ACCOUNTS ACCEPTED.**

PATIENT SIGNATURE_____ DATE _____

EYE HISTORY

( ) Contact Lenses
( ) Retinal Problem
( ) Eye Injuries
( ) Eye Surgery
( ) Cataracts
( ) Glaucoma
( ) Macular Degen.
( ) Other Eye Disease

MEDICAL HISTORY

( ) Allergies/Sinus
( ) Diabetes
( ) High Blood Pressure
( ) Heart Disease
( ) Stroke
( ) Thyroid Disease
( ) Arthritis
Other_____

( ) Alcohol/Tobacco
( ) Ulcer
( ) Cancer
( ) Kidney Stones
( ) Bronch/Emphysema
( ) Asthma
( ) Major Surgery

CURRENT MEDICINES

_____ _____
_____ _____
_____ _____

ALLERGIES/DRUG REACTIONS/TYPE

_____
_____
_____

FAMILY HISTORY

( ) Glaucoma ( ) Other Eye Disease
( ) Macular Degeneration

SOCIAL HISTORY

( ) Live alone
( ) Wear sunglasses
( ) Use computer
( ) Care Center
( ) Exercise
( ) Crafts