Welcome Hocking Eye Care! Thank you for trusting us with your eye care and vision needs!

Name:Dr.Mr.Mrs.Ms. _____ Preferred/Nick Name _____ Date of Birth _____

Address: _____ Home Phone: _____

City: _____ State _____ Zip _____ Cell Phone: _____

Occupation/Employer _____ full-time/part time Preferred Language _____ Race _____

Ethnicity _____ Marital Status _____ Hobbies: _____

Spouse/Parent/Guardian _____ Family Dr. Name/Phone # _____

Responsible Party (Policy Holder) _____ **Policy Holder DOB** _____

Medical Insurance Company _____ **Policy Holder SS #** _____

Secondary Medical Insurance _____ **Vision Insurance** _____

Glasses Worn:

- ○ Do not wear
- ○ Distance/Driving Only
- ○ Near/Reading Only
- ○ Full time

Contact Lenses worn:

- ○ Do not Wear
- ○ Daily Wear
- ○ Extended Wear
- ○ I would like to try Contacts

Age of Current Glasses _____

PERSONAL Medical History-Have you ever been diagnosed/treated for any of the following

○ Cataracts	○ Eye Injury (trauma, metal)	○ Diabetes	○ Thyroid Disease
○ Retinal Detachment	○ Glaucoma	○ Heart Disease	○ Migraines
○ Eye Surgery	○ Dry Eye	○ Asthma	○ High Blood Pressure
○ Macular Degeneration	○ Auto Immune Disorder	○ Cancer	○ Arthritis
○ Color Blindness	○ Lazy Eye/ Eye Turn	○ Elevated Cholesterol	○ Allergies/Hayfever

Other- Provide Details Here: _____

Please indicate who in your FAMILY has any of the following conditions? Specify which family member(s)

○ Heart Disease _____	○ Glaucoma _____	○ Blindness _____
○ Diabetes _____	○ Cataracts _____	○ Retinal Detachment _____
○ High Blood Pressure _____	○ Macular Degeneration _____	○ Other _____

List of Medications- both Prescription and Over the Counter

_____

_____

_____

_____

What eye drops do you use? _____

Are you allergic to any medications? _____

Do you Smoke? Never Some Days Every Day _____# Packs/day Former Smoker

Do you Drink Alcohol? Never Daily Rarely _____ # Drinks per week

Email Address: _____