PATIENT INFORMATION RECORD
(please print both sides)

Date _____/_____/_____

NAME _____
(Last) (First) (Middle)

MARITAL STATUS _____ GENDER Male / Female

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME # ( ) _____ WORK # ( ) _____

CELL # ( ) _____ EMAIL _____

BIRTHDATE ____/_____/_____ ARE YOU A FORMER PATIENT? ____YES ____ NO

EMPLOYER _____ OCCUPATION _____

S.S.N_____-_____-_____

HAS YOUR NAME CHANGED SINCE YOUR LAST EXAM? ____YES ____ NO
FORMER NAME: _____

IF PATIENT IS DEPENDENT, NAME OF PERSON RESPONSIBLE FOR ACCOUNT:

_____

ADDRESS: _____ PHONE ( ) _____

_____

WHOM MAY WE THANK FOR REFFERING YOU? _____

PREFERED METHOD FOR YEARLY RECALL

EMAIL_____ PHONE_____MAIL_____.

No Personal Checks

(IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED)

INSURANCE CO. _____

(WE DO NOT ACCEPT ASSIGNMENT OF INSURANCE BENEFITS. WE WILL BE HAPPY TO PROCESS YOUR FORMS, BUT THE BILL MUST BE PAID AT DELIVERY)

PLEASE COMPLETE OTHER SIDE OF FORM IF BEING EXAMINED

CASE HISTORY

a. DATE OF THE LAST EXAM _____ DILATED? _____

b. REASON FOR THIS EXAM: _____ NOT SEEING WELL _____ HEADACHE

_____ EYE STRAIN _____ OTHER _____

c. ARE YOU INTERESTED IN: _____ GLASSES _____ CONTACTS

HAVE YOU EVER WORN: _____ GLASSES _____ CONTACTS

d. LIST ANY HOBBIES THAT REQUIRE SPECIFIC VISUAL REQUIREMENTS:

_____

e. HOW OFTEN DO YOU USE A COMPUTER? _____

f. HAVE YOU EVER HAD DIFFICULTY
ADJUSTING TO PRESCRIPTION CHANGES? _____ **YES** _____ **NO**

MEDICAL HISTORY

a. HAVE YOU EVER HAD AN EYE INJURY, EYE INFECTION, EYE DISEASE OR EYE OPERATION?

_____ **NO**
_____ **YES** / EXPLAIN _____

b. DO YOU HAVE A FAMILY HISTORY OF:

(CIRCLE YES OR NO)		(FAMILY HISTORY)
YES	**NO**	DIABETES _____
YES	**NO**	HIGH BLOOD PRESSURE _____
YES	**NO**	CATARACTS _____
YES	**NO**	GLAUCOMA _____
YES	**NO**	MACULAR DEGENERATION _____
YES	**NO**	RETINAL DETACHMENT _____
YES	**NO**	ALLERGIES_____
YES	**NO**	MEDICATION ALLERGIES _____
YES	**NO**	OTHER _____

c. HOW IS YOUR PRESENT HEALTH? _____ GOOD _____ FAIR _____ POOR

d. ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____ **YES** _____ **NO**

NAME OF DRUGS: _____

e. DO YOU USE: CIGARETTES / TOBACCO? _____ **YES** _____ **NO**

ALCOHOL? _____ **YES** _____ **NO**