Patient Demographics

Today's date: ____/____/______

Last Name: ______________________________

First Name: ______________________ M.I.____

Date of birth: ___/___/_____

Preferred Name: ____________________________
(if different than legal name)

Occupation: ____________________________

What is the main reason for your visit today?

________________________________________

________________________________________

Do you currently wear glasses?

- ☐ No
- ☐ Yes, full time
- ☐ Yes, reading only
- ☐ Yes, distance only

Do you currently wear contacts lenses? **YES** or **NO**

☐ I would be interested in wearing contact lenses.

Have you had Lasik surgery? **YES** or **NO**

☐ I would be interested in Lasik surgery.

Please list all medications you currently take:

________________________________________

________________________________________

________________________________________

________________________________________

☐ I take Aspirin daily.

Do you have any allergies? ☐ No known allergies

| Medication/Material | Reactions you experience: |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

Do you have any of these eye symptoms?

- ☐ Blurred distance
- ☐ Blurred Reading
- ☐ Double Vision
- ☐ Glare or halos
- ☐ Flashing light
- ☐ Floaters
- ☐ Red eyes
- ☐ Dry eyes
- ☐ Tearing
- ☐ Burning
- ☐ Itching
- ☐ Pain
- ☐ Foreign body sensation
- ☐ Other: ____________

| FOR PROVIDER USE ONLY<br>List insurance provider and ID for billing purposes | |
| --- | --- |
| **Medical:** | ID#: |
| **Vision:** | ID#: |

Do you currently or have you had any of these eye conditions?

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Serious eye injury
- ☐ Iritis or Uveitis
- ☐ Lazy eye
- ☐ Retinal Detachment
- ☐ Wore an eye patch
- ☐ Other: ______________________

Do you currently or have you had any of these conditions?

- ☐ Stroke
- ☐ Dizziness
- ☐ Arthritis
- ☐ Heart disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Lung disease
- ☐ Cancer
- ☐ Anemia
- ☐ Thyroid disease
- ☐ Headaches
- ☐ High blood pressure
- ☐ Other: ____________

Have members of your immediate family (father, mother, siblings, or grandparents) had any of these eye diseases?

- ☐ Stroke
- ☐ Dizziness
- ☐ Arthritis
- ☐ Heart disease
- ☐ Diabetes
- ☐ AIDS
- ☐ HIV
- ☐ Lung disease
- ☐ Cancer
- ☐ Anemia
- ☐ Thyroid disease
- ☐ Headaches
- ☐ High blood pressure
- ☐ Other: ____________

It is your responsibility to know your insurance policy and to be familiar with your coverage. ***Our relationship is with you – not your insurance company.*** Any amount presumed to be approved by your insurance company, *but not paid,* will be your responsibility. **All insurance cards must be provided at the time of service.** If all your insurance information is not provided and accurate, this office will take no responsibility to submit insurance claims on your behalf, any insurance filing will be your responsibility.

I have read and understood my responsibilities to provide complete and accurate information.

➢ ________________________________

Patient Signature (or legal guardian)