Patient Information

Name:______________________________________ DOB:________________ Gender:______________
Address:____________________________________ City:_________________ State:_____ Zip: _______
Home Phone:__________________Cell Phone:_______________________ Texting: Yes___ No___
Email:_________________________________ Preferred Contact:: Home___ Cell___ Email___

Insurance Information

(If applicable)

Insurance Company Name: ___________________________ Member ID/SS#:_____________________
Primary Member Name:______________________________ Primary Member DOB:__________________
Relationship to Primary:______________ Member Employer:________________ Group #:_____________

Please attach all insurance cards to the clipboard

Check if you have any of the following:

__ Blurred Vision
__ Headaches
__ Glare from lights at night
__ Burning or Tearing Eyes
__ Itchy Eyes
__ Dry Eyes
__ Floaters
__ Flashes of light
__ Red Eyes
__ Cataracts
__ Glaucoma
__ Macular Degeneration
__ Pain in or around Eyes
__ Double Vision
__ Lazy Eye
__ Sensitivity to sunlight

Please check all of the following conditions you or a family member have or have had. Please provide any details that you think might be helpful.

Surgeries (including refractive surgery):____
__ Self __ Family __None **Diabetes**:____
__ Self __ Family __None **Allergies:** ____
__ Self __ Family __None **Immune System** (HIV, Lupus, MS,etc):____________________________________
__ Self __ Family __None **Sinus**:____
__ Self __ Family __None **Respiratory** (Lungs, T.B., etc):____
__ Self __ Family __None **Cardiovascular** (heart, High Blood Pressure, etc):___________________________
__ Self __ Family __None **High Cholesterol:**____
__ Self __ Family __None **Stomach, Colon:**____
__ Self __ Family __None **Neurological** (Seizures, Paralysis, etc):___________________________________
__ Self __ Family __None **Arthritis, Bones, Joints, Muscles**:____
__ Self __ Family __None **Hepatitis**:____
__ Self __ Family __None **Endocrine** (Thyroid, etc):____
__ Self __ Family __None **Skin, Changes in Skin:**____
__ Self __ Family __None **Blood** (Anemia, Dyscrasias, etc):_____________________________________
__ Self __ Family __None **Behavioral** (Depression, etc):_______________________________________
__ Self __ Family __None **Eye** (Cataracts, Retinal Problems, etc.):_________________________________
Are you allergic to any medications? If so please list:____
What medications are you currently taking?:____
Is there anything else we should know?:____

Federal Government Affordable Care Act Compliance Section

Height:______________________________
Weight:_____________________________
Hobbies:____________________________
Occupation:__________________________
Race:_______________________________
Ethnicity: ___________________________

Do you:
Smoke: Yes___ No___
Substance: Tobacco Other:______________
Drink(Alcohol): Yes___ No___
Number of drinks a day:______

Are there any special accommodations we need to make for you?:_________________________________
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