Patient Information:

Name: ___________________________
Date of birth_____/______/______
Address: _________________________
____
SSN: ____________________________
Email: ___________________________
Preferred Language: ______________
Race: ____________ **Ethnicity:** _____
Height: _________ **Weight:** ________
Phone: (____) ____________________
Cell Phone: (____) ________________

Health Insurance: ______________________________________
Vision Insurance: ______________________________________
Name of Insured: _______________________________________
SSN of Insured: ____
Birthday of Insured: ___________/____________/____________
Tobacco Use: Yes No Former smoker
If yes, how long _____ / # of packs_____
Alcohol Use: No Yes
If yes, how many drinks per week? _____
Exposed to or infected with a STD Yes No
Marital status: ______________ **Spouse:** ____________________

Digital retinal imaging provides instant photos of the inside of your eyes. They are used to track or diagnose abnormal eye conditions. Our fee for this service is $35.00. (Children 12 and under have no charge).

ACCEPT **DECLINE** **SPEAK WITH DR.**

Dilation allows a more thorough examination of the eye. Our doctors recommend new patients and require all diabetic patients to be dilated. **ACCEPT** **DECLINE** **SPEAK WITH DR.**

AMD Risk Assessment identifies age related macular degeneration. It is recommended for all patients over 21. The cost for this test is $15. **ACCEPT** **DECLINE** **SPEAK WITH DR.**

Family doctor: __________________________________**Last Visit**: _______________________________
Pharmacy: ____
Please check if you are you interested in: glasses _____ or glasses and contacts ______
Please check any conditions that you are currently experiencing or diagnosed with:

Blurred Vision	___	Light Sensitivity	___	Diabetes (Type 1/Type 2)	___
Burning	___	Loss of Vision/Side Vision	___	Emphysema	___
Chalazion or Stye	___	Migraines	___	Fever, Weight loss/Gain	___
Double Vision	___	Mucous Discharge	___	Genitals/Kidney/Bladder	___
Dryness	___	Redness	___	Heart Attack	___
Eye Pain or Soreness	___	Seizures	___	Heart Disease	___
Flashes/Floaters in Vision	___	Tearing/Watering	___	High Blood Pressure	___
Foreign Body/Gritty/Sandy	___	Tired Eyes	___	Joint Pain/Muscle Pain	___
Glare	___	Twitching Eyelid	___	Pregnant / Nursing	___
Halos/Distorted Vision	___	Allergies/Sinus Congestion	___	Psychiatric/Depression	___
Headaches	___	Anemia/Bleeding Problems	___	Stroke	___
Infection (Eye/Lid)	___	Arthritis/Rheumatoid	___	Thyroid/Other Glands	___
Injury/Trauma/Surgery	___	Asthma	___	OTHER Explain_____________	
Itching	___	Chronic Bronchitis	___		

Please list all major injuries, surgeries, and/or hospitalizations_________________________________
____
Medication: ____
____
____
Seasonal or Medication Allergies: ____
____

Patient / Guarantor signature____ **Date**______________________