



PATIENT INFORMATION				DATE:	
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	
				GENDER: ☐ Male ☐ Female	
DATE OF BIRTH:		AGE:		SOCIAL SECURITY #	
OCCUPATION:		DATE OF LAST EYE EXAM:			
MARITAL STATUS:	☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other				
ADDRESS		APT#		CITY	
				STATE	
				ZIPCODE	
HOME PHONE:		CELL PHONE:		OTHER PHONE:	
E-mail:					
PRIMARY CARE PHYSICIAN:			PHYSICIAN PHONE:		
CONDITIONS: Check (✓) condistions you have or have had in the past					
☐ BLURRED VISION ☐ CATARACTS ☐ CROSSD EYES ☐ DIABETES ☐ DOUBLE VISION		☐ EYE INFECTION ☐ EYE INJURY ☐ EYE SURGERY ☐ FLOATERS ☐ GLAUGOMA		☐ HEADACHES ☐ HYPERTENS ON ☐ LOSS OF VISION ☐ RETINAL DISEASE ☐ SEEING FLASHES	
				☐ SEEING HALOS ☐ SENSITIVITY TO LIGHT ☐ WEAR CONTACT LENSES TYPE OF LENSES: HOURS PER DAY:	
Check (✓) if your blood relatives had any of the following:		RELATIONSHIP TO YOU:		ALLERGIES you have to medications or substances	
BLINDNESS					
CATARACTS					
DIABETES				MEDICATIONS List medications you are currently taking	
GLAUCOMA					
INSURANCE INFORMATION					
PERSON RESPONSIBLE FOR ACCOUNT:					
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	
DATE OF BIRTH:		SOCIAL SECURITY #		RELATION TO PATIENT:	
SUBSCRIBER I.D. #					
PPO ONLY					
ISURANCE NAME			ISURANCE PROVIDER PHONE #		
INSURANCE ADDRESS		CITY		STATE	
				ZIPCODE	