NEW PATIENT INFORMATION

GENERAL INFORMATION

First Name, Middle Initial:		Phone:	
Last Name:		Email:	
Preferred Name:		Preferred Communication:	Call Email Text
Birthdate:		Employer:	
Gender:		Occupation:	
S.S.N:		Work Phone:	
Race:		Emergency Contact:	
Marital Status:		Phone:	
Address:		Primary Care Provider:	
City:		Phone:	
State, Zipcode:		Pharmacy:	
Who referred you?		Phone:	

INSURANCE INFORMATION

Medical Insurance:		Vision Insurance:	
Subscriber Number:		Subscriber Number:	
Group Number:		Group Number:	
If you are not the policy holder, complete the following:		*If you are not the policy holder, complete the following:*	
Subscriber Name:		Subscriber Name:	
Date of Birth:		Date of Birth:	
Address:		Address:	
City, State & Zipcode:		City, State & Zipcode:	

PATIENT INFORMATION

Reason for Visit:		Allergies:	
Medications/Supplements:		Hobbies/Activities:	

PATIENT & FAMILY HISTORY

Circle all that apply	**Self**		**Family**	
	Glaucoma	Amblyopia	Glaucoma	Amblyopia
	Cataracts	Strabismus (Eye Turn)	Cataracts	Strabismus (Eye Turn)
	Macular Degeneration	Eye Injuries	Macular Degeneration	Eye Injuries
	High Blood Pressure	Eye Surgery	High Blood Pressure	Eye Surgery
	High Cholesterol	Carcinoma (Cancer)	High Cholesterol	Carcinoma (Cancer)
	Diabetes Type I	Diabetes Type II	Diabetes Type I	Diabetes Type II
	Other (Please Specify):		Other (Please Specify):	

Vision Difficulties:	While Driving	Distance	Night	Close-Up	Computer/Intermediate
Sensitivity to:	Fluorescent Lights	Sunlight	Glare from devices (Computer, Tablet, Cell Phone)		Other: _____
Do your eyes:	Burn	Water	Ache	Itch	Experience Redness
Are your eyes:	Dry	Sore	Swollen	Fatigued	Strained
Do you wear:	Contact Lenses	Type _____		Glasses	Type _____
Hours at Computer:	_____		Interested in Lasik?	Yes	No