

Please complete this confidential patient information form **PLEASE PRINT**

Today's Date: _____

Name: _____
FIRST NAME M.I. LAST NAME

Gender: Male Female Age: _____ Date of Birth: _____
MM/DD/YYYY

Marital Status: Single Married Divorced Widowed Social Security #: _____

Patient's Current Mailing Address:

STREET ADDRESS APT # CITY STATE ZIP CODE

Home Phone #: () _____ Cell: () _____ Email: _____

Person Responsible For Payment: *(If different from above)* _____
()

NAME STREET ADDRESS APT # CITY STATE ZIP CODE PHONE #

Patient's or Responsible Party's Employment

OCCUPATION/EMPLOYER STREET ADDRESS CITY STATE ZIP CODE PHONE #

Will you be using insurance? YES NO *If yes please fill out the following information to the best of your ability:*

INSURANCE CARRIER MEMBER'S NAME MEMBER'S SSN MEMBER'S BIRTH DATE

MEDICAL HISTORY

Primary Care Physician: _____ When was your last eye examination? _____

Have you ever worn contact lenses? YES or NO Are you interested in contact lenses? YES or NO

List all medication you are presently using:

List any medication you may be allergic to:

Diagnosed Conditions:

- Stroke Glaucoma Thyroid Disease Allergies or Asthma Hardening of the Arteries
- Arthritis Migraines Venereal Disease Kidney Disease High Blood Pressure
- Cancer Heart Disease Tuberculosis Serious Head Injury Seizures (Epilepsy)
- Diabetes Other High Cholesterol

Please check any eye conditions that apply:

- Light Flashes Floaters Double Vision Color Blindness Difficulty seeing at night
- Dryness Trouble Reading Sensitivity to light Burning Discharge from eyes
- Episodes of temporary loss of vision Excessive watering Other

Please list any previous eye diseases, injuries and/or surgeries:

Female Patients:

Are you pregnant? YES or NO Are you taking any oral contraceptives? YES or NO _____

PLEASE LIST

By signing below, I certify that the above information is correct to the best of my knowledge.

Signature (Patient, Parent or Guardian)