Family Eye Care
Optometry

Dr. Jeffrey Garcia O.D.
and Associates

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 □ Wido **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)