Patient Personal and Medical Information

Name ______________________________ Date ______/______/______
Guardian ______________________ Marital Status ______________________
Address ____
City ______________________________ State __________ Zip ____________
Home Phone ____________ Work Phone ____________ Cell Phone____________
Date of Birth ______/______/______ Social Security Number ________-______-__________
E-Mail ______________________ (Used for appointment reminders & limited practice information)
Occupation ____________________ Employer______________________
Hours / Day Computer Work__________ Hobbies / Sports ____________________

Referred by another doctor? ______________________________________

Please circle if you have any of the following eye conditions:

Keratoconus Cataracts Glaucoma Lazy Eye Diabetes Retinal Detachment
Macular Degeneration Eye Infection High Blood Pressure Allergies

List any other medical problems______________________________________
Have you ever had any injury or surgery to your eyes? Yes No
Describe____
Do you presently wear contact lenses? Yes No
Which type do you currently wear? Disposable Hard Scleral Hybrid
Did you bring a list of current medications today? Yes No
IF NOT, please list any medications: ______________________________
____

Are you allergic to any medications? ______________________________

PLEASE HAND MEDICAL AND VISION INSURANCE CARDS TO FRONT DESK

.

I give my consent to release health information to: (Family Member, Friend, etc.)

Name ______________________ All Records / Medical Only / Financial Only

Name ______________________ All Records / Medical Only / Financial Only

Lifetime Patient Signature ______________________ Date ______/______/__________