PATIENT FORM

Reset Form

GENERAL INFORMATION

Last, First, MI, Preferred Name

Street Address

City, State, Zip

Phone 1 ◯ *home* | ◯ *mobile* | ◯ *work* *Receive appointment reminders via text:* ◯ *yes* | ◯ *no*

Phone 2 ◯ *home* | ◯ *mobile* | ◯ *work*

Email

Sex ◯ *Male* | ◯ *Female* *date of birth*

Patient Social Security #

Marital Status ◯ *married* | ◯ *single* | ◯ *divorced* | ◯ *legally separated* | ◯ *widowed*

Employer/Occupation ◯ *full-time* | ◯ *part-time*

How Did you Find us? ◯ *internet* | ◯ *insurance* | ◯ *VSP* | ◯ *referred by:*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name (Last, First, MI)

Vision Insurance Member ID# Group ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name (Last, First, MI)

Insurance ID# Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member ◯ *spouse* | ◯ *child* | ◯ *other (explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name (Last, First, MI)

Secondary Medical Insurance ID# Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member ◯ *spouse* | ◯ *child* | ◯ *other (explain)*

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses? ◯ *yes* | *no* ◯

Type? ☐ *distance* | ☐ *reading* | ☐ *progressive*

☐ *trifocal* | ☐ *bifocal* | ☐ *sun*

Currently Wear Contacts? ◯ *yes* | *no* ◯

Brand?

How often?_____hours/day_____days/weeks

Have you or a family member experienced, or been treated for, any of the following? Check all that apply.

Cataracts	☐ *yes*	☐ *no*	☐ *family*
Crossed Eye	☐ *yes*	☐ *no*	☐ *family*
Glaucoma	☐ *yes*	☐ *no*	☐ *family*
LASIK or PRK	☐ *yes*	☐ *no*	☐ *family*
Lazy Eye	☐ *yes*	☐ *no*	☐ *family*
Macular Degeneration	☐ *yes*	☐ *no*	☐ *family*
Retinal Detachment	☐ *yes*	☐ *no*	☐ *family*

Other (Explain)

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

☐ Blurry Vision ☐ *distance* ☐ *reading* ☐ *computer*

☐ Burning

☐ Discharge

☐ Double Vision

☐ Dryness

☐ Excess Tearing/Watering

☐ Eye Infection

☐ Eye Pain or Soreness

☐ Floaters or Spots

☐ Halos

☐ Headaches

☐ Itching

☐ Light Flashes

☐ Light Sensitivity

☐ Redness

☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Check all that apply.

AIDS/HIV	☐ *yes*	☐ *no*	☐ *family*
Allergies	☐ *yes*	☐ *no*	☐ *family*
Arthritis	☐ *yes*	☐ *no*	☐ *family*
Asthma	☐ *yes*	☐ *no*	☐ *family*
Blood/Lymph Disorder	☐ *yes*	☐ *no*	☐ *family*
Cancer	☐ *yes*	☐ *no*	☐ *family*
Diabetes ☐ (type 1) ☐ (type 2) ☐ (*hba1c* _____)	☐ *yes*	☐ *no*	☑ *family*
Ears, Nose, Throat Conditions	☐ *yes*	☐ *no*	☐ *family*
Gastrointestinal Conditions	☐ *yes*	☐ *no*	☐ *family*
Heart Disease	☐ *yes*	☐ *no*	☐ *family*
High Blood Pressure	☐ *yes*	☐ *no*	☐ *family*
High Cholesterol	☐ *yes*	☐ *no*	☐ *family*
Kidney Disease	☐ *yes*	☐ *no*	☐ *family*
Lupus	☐ *yes*	☐ *no*	☐ *family*
Neurological Conditions	☐ *yes*	☐ *no*	☐ *family*
Psychiatric Disorder	☐ *yes*	☐ *no*	☐ *family*
Seizures	☐ *yes*	☐ *no*	☐ *family*
Skin Conditions	☐ *yes*	☐ *no*	☐ *family*
Stroke	☐ *yes*	☐ *no*	☐ *family*
Thyroid Dysfunction	☐ *yes*	☐ *no*	☐ *family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height	Weight		
Are you pregnant or nursing?	◯ *yes*	◯ *no*	
Do you smoke?	◯ *yes*	◯ *no*	*years*
Do you drink alcohol?	◯ *yes*	◯ *no*	
Do you use narcotics?	◯ *yes*	◯ *no*	