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Please complete the information below and submit the form online, or if you prefer print out the form after full or partial completion, and bring it when you come to our office. This form contains confidential information and is delivered to your doctor through a secure Internet connection.

Patient Information

Name

Prefix

First

Last

Suffix

Address *

Street Address

City

State

Zip

Phone Number *

(###) ###-####

Daytime Phone

(###) ###-####

Cell Phone

(###) ###-####

Email Address

Personal Information

Gender *

Male Female

Date of Birth *

Day

Month

Social Security Number *

(last 4 digits only!)

Year

Preferred Language *

Select >

Race *

Select >

Ethnicity *

Select >

Marital Status

Select >

Employment Status

Select >

Employer

Occupation

How were you referred to our office?

Select >

Communication Preference

Eye History

Please check off any current conditions you suffer from

I stopped wearing glasses | I stopped wearing contact lenses | Headaches

Glare/Light Sensitivity | Tired Eyes | Amblyopia (lazy eye) | Burning

Dryness | Watery Eyes | Eye Pain and/or Soreness

Foreign Body Sensation | Infection of Eye or Lid | Itching

Mucous Discharge | Drooping eyelid(s) | Redness

Sandy or Gritty Feeling | Strabismus (crossed eye) | Blurred Vision at Distance

Blurred Vision at Near | Haloes | Double Vision | Floaters or Spots

Fluctuating Vision | Loss of Vision | Loss of Side Vision

Glasses History

Do you wear glasses? *

Yes | No

Contact Lens History

Do you wear contact lenses? *

Yes | No

Medical History

When, approximately, was your last eye exam?

Where did you get your last eye exam?

When, approximately, was your last physical exam?

Who is your primary care physician?

Do you drink alcohol?

Select >

Do you smoke?

Select >

Please list all medical conditions you have ever had (Diabetes, High blood pressure, Arthritis, etc.)

Please list all eye conditions you have ever had (Glaucoma, Cataract, Wandering or Lazy eye, Retinal detachment)

Please list all eye conditions you have ever had (Glaucoma, Cataract, Wandering or Lazy eye, Retinal detachment)

Please list any medical or eye conditions that run in your family (blood relatives) (Diabetes, High blood pressure, Cancer, Glaucoma, Macular degeneration, etc.)

Please list all hospital surgeries you have ever had:

Please list all prescription and over-the-counter medications you take and for what conditions

Please list all drug allergies you have

Please check off any current conditions you suffer from

- [ ] Chronic fever, unexpected weight loss/gain, fatigue
- [ ] Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)
- [ ] Heart problems (eg. Chest pain, irregular heart beat, swelling of feet, cold hands or feet)
- [ ] Respiratory problems (eg. Shortness of breath, wheezing, coughing)
- [ ] Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting)
- [ ] Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)
- [ ] Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)
- [ ] Skin problems (eg. Rashes, excessive dryness, growths or lumps)
- [ ] Neurological problems (eg. Numbness, weakness, headaches, “blackouts”)
- [ ] Psychiatric problems (eg. Depression, anxiety)
- [ ] Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)
- [ ] Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)
- [ ] Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens)

Primary Insurance

Please bring all insurance cards with you to your appointment.

Insurance Company Name

Insurance Company Phone Number

(###) ###-####

Address

Street Address

Address Line 2

City

Insured's Name

First

Last

Identification Number

Group Number

Insured's Date of Birth

Day

Month

Year

Patient's Relation to Insured

Secondary Insurance

Do you have secondary insurance?

Yes No

Comments

If you have any comments you would like to add, please enter them here.

Privacy Policy

Health Information Protection *

I have read and agree to the Privacy Policy

Submit