

Patient Information

Patient Information

Patient First Name	
Patient Last Name	
Date of Birth	
Gender	<input type="radio"/> Male <input type="radio"/> Female
Email:	
Mobile Phone:	
Street Address:	
City:	
State:	
ZIP Code:	
Reason for visit:	<input type="checkbox"/> Glasses Exam <input type="checkbox"/> Contact Lenses Exam <input type="checkbox"/> Yearly Eye Health Check <input type="checkbox"/> Diabetic Eye Exam <input type="checkbox"/> Follow-up <input type="checkbox"/> Other
Other (please explain)	

Insurance Information

Do you have any vision insurance?	<input type="radio"/> Yes <input type="radio"/> No
	<input type="checkbox"/> I agree that I must provide office staff with any vision or medical insurance information, along with a photo ID, at the time of service. Billing is completed at the time of service and cannot be changed after the exam date. <input type="checkbox"/> I agree to pay out of pocket if I do not have, or do not provide any insurance information. Insurance information must be given to office staff at time of service. The office is not able to bill insurance at a later date.
Eye Health History (Check all that apply)	
	<input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> None
	<input type="checkbox"/> Retinal tear/detachment <input type="checkbox"/> Injury <input type="checkbox"/> Other
Please indicate any eye surgeries you have had (Check all that apply)	
	<input type="checkbox"/> Cataract Surgery (Both Eyes) <input type="checkbox"/> Cataract Surgery (Right Eye Only) <input type="checkbox"/> Cataract Surgery (Left Eye Only) <input type="checkbox"/> LASIK/RK/PRK
	<input type="checkbox"/> Glaucoma Surgery <input type="checkbox"/> Retinal Surgery <input type="checkbox"/> Other <input type="checkbox"/> None
If other, please explain:	
Check any symptoms that apply:	

	<input type="checkbox"/> Dry eyes <input type="checkbox"/> Excess tearing <input type="checkbox"/> Double vision <input type="checkbox"/> Red eye <input type="checkbox"/> Flashing Lights <input type="checkbox"/> Halos Around Lights
	<input type="checkbox"/> Light sensitivity <input type="checkbox"/> Eyes itch <input type="checkbox"/> Eyes burn <input type="checkbox"/> Floaters in vision <input type="checkbox"/> Loss of vision
Please indicate any systemic diseases you have ever been told you have:	
	<input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> High Blood Pressure (Hypertension) <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Arthritis
	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Thyroid <input type="checkbox"/> Cancer <input type="checkbox"/> Other <input type="checkbox"/> None
If replied YES, to DIABETIC, provide most recent A1C:	
If replied YES, to DIABETIC, provide doctor's name and phone number	
If replied YES, to DIABETIC, provide doctor's name and phone number	
Please list any medications that you are currently taking:	
Please list any medications you are allergic to:	
	<input type="checkbox"/> I agree that if I have any issues with the fit or clarity of my prescription, I will notify the office within 60 days of my scheduled appointment, or I may be subject to additional fees for prescription adjustment.
E-Signature:	