



First Name: _____ Last Name: _____

DOB: _____ Parent/Guarantor: _____

Address: _____ City: _____

State/Zip: _____ Phone #: _____ Email: _____

Nickname/preferred Name: _____ Occupation: _____

How did you hear about us?: _____

Insurance Information

Vision Ins: _____ SSN/ID#: _____ Subscriber Name: _____

Major Medical Ins: _____ ID#: _____ Subscriber DOB: _____

PCP Name: _____ PCP Phone #: _____

Reason You Are Here: _____ Do You Wear: Eyeglasses Contacts

Date of Your Last Eye Exam: _____ Past Eye Surgeries: _____

Your health History: Please Check ALL That Apply To YOU.

Family History:

- | | | |
|---|--|---|
| <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> GI Conditions | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Skin Conditions (Eczema, Psoriasis) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Dry Eye Itchy Eyes Redness | <input type="checkbox"/> Psychiatric Disorders | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> ENT Conditions | <input type="checkbox"/> Unknown/adopted |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lazy Eye | |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Macular Degeneration | |
| <input type="checkbox"/> Respiratory Conditions | | |

Pregnant/Nursing: Yes No Known Drug Allergies: _____

Social Hx: Smoke Vape Alcohol How Often: Socially Occasionally In The Past

Please list any current medications: _____

Privacy Information: We want our patients to know that we have a privacy policy in place for your protection. You have a right to review the Notice of Privacy at any time. Please acknowledge with your signature below you have read the Notice.

I, the undersigned, certify that I, or my dependent, have answered all questions above truthfully to the best of my ability. I understand it is my financial responsibility for all charges whether or not paid by my insurance company.

Responsible Party Signature

Date