EXAM DATE / /

BOYLE eye specialists

3 West Olive Street • Scranton, PA 18508 • (570) 558-5566

PATIENT INFORMATION

FIRST NAME | LAST NAME | ☐ MALE ☐ FEMALE | DATE OF BIRTH | AGE (YRS)

ADDRESS | CITY & STATE | ZIP CODE

PREFERRED PHONE NUMBER | ☐ HOME ☐ WORK ☐ CELL | SECONDARY PHONE NUMBER | ☐ HOME ☐ WORK ☐ CELL | EMAIL ADDRESS

SOCIAL SECURITY | EMPLOYER | SIGNATURE

INSURANCE INFORMATION

MEDICAL INSURANCE

PLAN NAME | ID #

ABOUT THE PRIMARY CARDHOLDER: (if self, okay to omit)

FIRST NAME | LAST NAME | ☐ MALE ☐ FEMALE

DATE OF BIRTH / / | SOCIAL SECURITY

EMPLOYER | RELATIONSHIP TO PATIENT ☐ PARENT ☐ CHILD ☐ SPOUSE ☐ SELF

SUPPLEMENTAL / VISION INSURANCE

PLAN NAME | ID #

ABOUT THE PRIMARY CARDHOLDER: (if self, okay to omit)

FIRST NAME | LAST NAME | ☐ MALE ☐ FEMALE

DATE OF BIRTH / / | SOCIAL SECURITY

EMPLOYER | RELATIONSHIP TO PATIENT ☐ PARENT ☐ CHILD ☐ SPOUSE ☐ SELF

SPECIALIST COPAY:

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S VISIT?

ARE YOU PLANNING TO GET NEW GLASSES TODAY? ☐ YES ☐ NO | ARE YOU PLANNING TO GET NEW CONTACTS TODAY? ☐ YES ☐ NO | AGE OF PRESENT GLASSES | AGE OF PRESENT SUNGLASSES | YEAR OF LAST EYE EXAM

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER, OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE
DIABETES			
HIGH BLOOD PRESSURE			
THYROID PROBLEMS			
HEART DISEASE			
ASTHMA			
CANCER			

	SELF	RELATIVE	NONE
GLAUCOMA			
CATARACTS			
RETINAL DISEASE			
EYE SURGERY			
EYE INJURY			
OTHER:			

	YES	NO
DO YOU SEE DOUBLE?		
FREQUENT HEADACHES?		
EYES FEEL DRY?		
EYES BEEN DILATED?		

PRIMARY CARE DOCTOR:

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST.

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST.

DO YOU HAVE ANY ALLERGIES; MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN.

PHARMACY: