Patient /Dependent Information

Name: (Last, First, MI)

_____

Male ☐ Female ☐ Today's Date _____

Mailing Address (City) (State) (Zip Code)

_____

Email_____ Home Phone _____

Alt. Phone _____ DOB _____ Age _____

Soc. Sec # _____

Occupation _____ Employer _____

Emp. Address _____ Emp. Phone _____

Patient/Guardian Information

Parent/Guardian_____ Mom ☐ Dad ☐ Guardian ☐

Occupation _____ Employer _____

Emp. Address _____ Emp. Phone _____

Parent SS# _____ Emergency Contact _____ Phone _____

Names of family members who have been patients here _____

How did you hear about us? _____

Insurance Holder Information

Insurance holder's name _____ Insurance Holders SS# _____

Occupation _____ Employer _____ DOB _____

Vision Insurance Company _____ ID# _____ Group # _____

Medical Insurance Company _____ ID# _____ Group # _____

Vision History

Last Vision Exam _____ Name of Eye Doctor _____

Please check all that apply

☐ Burning Eyes	☐ Color Vision Poor	☐ Discharge
☐ Dry Eyes	☐ Eye Infections	☐ Eye Injury
☐ Floaters or Spots	☐ Headaches	☐ Itching Eyes
☐ Temp Vision Loss	☐ Twitching Eye	☐ Watering Eye
☐ Dizzy Spells	☐ Double Vision	☐ Eye Strain
☐ Flashes or Halos	☐ Light Sensitive	☐ Red Eyes

Other Eye Problems _____

Do you wear contacts? ☐ Yes ☐ No

How Often? _____

Please check all that apply

Blurred Vision	☐ Near	☐ Distance
Cataracts	☐ Self	☐ Family
Glaucoma	☐ Self	☐ Family
Macular Degeneration	☐ Self	☐ Family
Migraine Headaches	☐ Self	☐ Family
Poor Night Vision	☐ Self	☐ Family
Retinal Problems	☐ Self	☐ Family

Do you wear glasses? ☐ Yes ☐ No

How Often? _____

Please continue to back of page

Health History

Medical Doctor _____ Date of Last Physical _____

Please check all that apply

☐ Allergies	☐ AIDS/HIV	☐ Arthritis	☐ Asthma	☐ Cancer	☐ Diabetes
☐ Drug Allergies	☐ Hepatitis	☐ Heart Condition	☐ High Blood Pressure	☐ Lupus	☐ Pacemaker
☐ Skin Condition	☐ Shingles	☐ Kidney Disease	☐ Rheumatic Fever	☐ Smoker	☐ Stroke
	☐ Other	☐ Thyroid Condition	☐ Turned Eye ☐ Right ☐ Left		

Please Specify Your Allergies _____

Current Medications _____

Pharmacy _____ Phone _____

Hobbies and Activities _____

I give consent for Eye Care for You, and its doctors to provide eye care and perform eye tests and exams on my child

Child's Name _____

Parent/Guardian Signature_____ Date_____