Annual Patient Information Form

Thank you for choosing us for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help!

Last name:_______________ First Name:_______________ M.I:_____ **Date:**__________
Address:____
City:__________ **State:**_______ **Zip Code:**________
Birth Date:__________ **Home Phone:**__________ **Work Phone:**__________ **Cell:**__________
Do you prefer to receive calls at: [ ] Home [ ] Work [ ] Cell
Mothers Maiden Name:______________ **Birth State:**_____ **Email:**______________
Employer:____
Occupation:______________________ **Gender:** [ ] Male [ ] Female
Marital Status: __________ **Race/Ethnicity:**______________
Are you a(n) [ ] Existing patient? [ ] New patient If new, where were you previously?__________
How did you hear about our office?______________________________

Insurance Information

Primary Card Holders Name:______________________________ **Birth Date:**__________
Address (if different then patient):______________________________
Relationship to patient:______________________________
Primary Insurance Type:____________________ **Insured ID Number:**__________
Secondary Insurance Type:____________________ **Insured ID Number:**__________

Health History

Reason for today's visit/ symptoms:______________________________
____

Date of last eye exam:______________

Do you or anyone in your immediate family have a history of the following:

Diabetes - [ ] Self [ ] Family
Cataracts - [ ] Self [ ] Family
Asthma - [ ] Self [ ] Family
Heart Condition - [ ] Self [ ] Family
Blindness - [ ] Self [ ] Family
Thyroid - [ ] Self [ ] Family
Stroke - [ ] Self [ ] Family
Color Blindness - [ ] Self [ ] Family
Glaucoma - [ ] Self [ ] Family
Cancer - [ ] Self [ ] Family
Turned or Lazy eye - [ ] Self [ ] Family
High Blood Pressure - [ ] Self [ ] Family

Please check for any of the following that apply to you:
[ ] Frequent headaches [ ] Allergies [ ] Sinus trouble [ ] Drug Allergies [ ] Pregnant

Please list all medications you are currently taking ______________________________
____

Have you ever had any of the following conditions involving your eyes?
[ ] Eye surgery [ ] Sensitivity to light [ ] Eye infection or disease [ ] Severe pain
[ ] Eye injury [ ] Floaters or spots [ ] Double Vision [ ] Poor near vision
[ ] Medical treatment [ ] Poor distance vision [ ] Eye strain [ ] Eyes burn, itch or water

Do you currently wear glasses? [ ] Yes [ ] No

When do you wear your glasses?
[ ] All the time [ ] Reading/near work [ ] Work safety
[ ] Distance tasks only [ ] Computer work [ ] Other__________________

Have you ever worn contacts? [ ]Yes [ ] No

Are you interested in wearing contacts? [ ] Yes [ ] No

What style are you currently wearing?
[ ] One day [ ] 2 week [ ] One month [ ] Multifocal [ ] Color

Do you work at a computer [ ] Yes [ ] No **Hours per Day:**__________

What hobbies or sports do you participate in?______________________________