Name:______________________________ Birthday:___________ Gender:_____________
Address (Mailing):____
City:_______________________________________ Zip Code:_________________
Email Address:____
Occupation:____
Phone (Cell/Home/Work):____
SSN Insured:________________________ Employer:_______________________________
Date of last eye exam:_______________ Reason for visit today:____________________

What are your visual symptoms? (Circle all that apply)

Blurry Distance Vision	Burning Eyes	Floaters or spots	Headaches
Blurry Near Vision	Itchy Eyes	Seeing Flashes	Migraine headache
Double Vision	Eye Injury	Dry Eyes	Poor night vision
Crosses/Turned Eyes	Eye Strain	Red Eyes	Light Sensitivity
Eye Infection	Watery Eyes	Lid Pain	Sandy/Gritty feeling

Do you wear glasses? Yes No If so, when do you? All the time/Reading/Work/Driving
Do you wear contact lenses: Yes No Type:____
Do you use tobacco? Yes No
Are you pregnant? Yes No
List Current MEDICATIONS (or provide list)_______________________________________
List ALLERGIES (meds or other)____

Medical History: SELF or FAMILY (Please write who or discuss with doctor)
Glaucoma___________ Cataracts__________ Eye Surgery___________Diabetes________
Macular Degeneration_________Retinal Detatchment________Crossed/Lazy eye______
Other Eye Disease___________Heart Disease_________High Blood Pressure__________
Mutiple Scleross___________Arthritis___________Astma________Cancer_____________
OTHER____

PLEASE SIGN both lines. We respect HIPAA to keep your health information private.
I Understand (sign)___________________________________ Date____________________
Insurance and Finance Policy (sign)____

****If you wish to give consent to access your account****

I,____, give my permission for
____ access my records.