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Patient Personal Information

First NameMI	Employer	
Last Name	Occupation	
Address	Home Phone	
City	Cell Phone	
StateZip	Work Phone	
Date of Birth//	Parent/Guardian	
Sex: M / F Marital Status: S / M / D / W	Emergency Contact	
	Emergency Phone	
Primary Care Office w/Location:		
Pharmacy w/Location:		
On-line Appointment Requests • Text No • Text Message Appoint	ext NOTIFICATIONS!! otifications of Completed Orders • Appointment Confirmations ntment Reminders • Satisfaction Surveys onsenting to receive email and/or text messages.	
Email:Cell:		
Patient Insurance Information: Relationship to Medical Ins. Carrier	Vision Ins	
ID#		
Group #	Group #	
Policy Holder's Name	m. P. H. Halda J. Manna	
Policy Holder's DOB//	Policy Holder's DOB / /	

Patient Medical History Name:			DOB:
What is the main purpose of this visit?			Year of last eye examination:
Were your eyes dilated at your last exam	? □ yes	□ no	
Have you ever had a dilated exam?	□ yes	□ no	Have you had LASIK/PRK surgery? ☐ yes ☐ no
Are you Pregnant?	□ yes	□ no	Dr's Name:
Are you Nursing?	□ yes	□ no	Date of Surgery:
Are you a Contact Lens Wearer?	□ yes	□ no	Are you interested in LASIK? □ yes □ no
Brand	-		
			_ _ Left Eye Rx
(include BC & DIA			(include BC & DIA parameters)
List all allergies (environmental or drug):			
Do you have Diabetes? ☐ yes ☐ no ☐ Type I ☐ Type II		-	ve you ever used tobacco products? □ yes □ noAmount: How long?
⊔ турет ⊔ туреті		туре	AITIOUITE HOW TOTIGE
Year diagnosed:			nk alcohol? □ yes □ no
Last HbA1C:		Type:	Amount: How long?
Have you ever been diagnosed/treat	ed for th	ne following	? Do you experience any of the following?
Cataracts	□ yes	□ no	Blurry Vision □ yes □ no
Glaucoma	□ yes	□ no	If so: □ distance □ near □ both
Macular Degeneration	□ yes	□ no	Difficulty at computer □ yes □ no
Retinal Detachment	□ yes	□ no	Difficulty driving at night □ yes □ no
Lazy Eye or Eye Turn	□ yes	□ no	Dry Eye ☐ yes ☐ no
Eye Injury	□ yes	□ no	Headaches □ yes □ no
Eye Surgery		□ no	Double Vision □ yes □ no
, , ,	,		Flashes of Light □ yes □ no
If yes, provide details:			Persistent Floaters □ yes □ no
, (23) provide details:			Eye Itching
			Eye Tearing
Have you ever been diagnosed or tre	ated for	any of the f	following problems? Explanation of Problem
Endocrine (thyroid, hormones, glands)	□ yes	□ no	
Cardiovascular (heart, blood vessels)	□ yes	□ no	
High Blood Pressure		□ no	
Respiratory (lungs, breathing)	□ yes	□ no	
Gastrointestinal (stomach, intestines)	□ yes	□ no	
Musculoskeletal (muscles, joints, arthritis) □ yes	□ no	
Integument (skin)	□ yes	□ no	
Neurological (migraines, seizures)	□ yes	□ no	
Psychiatric (anxiety, depression, etc)	□ yes	□ no	
Ears, Nose, Mouth, Throat	□ yes	□ no	
Hematologic/Lymphatic (anemia, etc)	□ yes	□ no	
Allergic/Immunologic	□ yes	□ no	
HIV/AIDS	□ yes	□ no	

Do you have a family	medical history	of any of the following:	•
Glaucoma	□yes □no	Relationship:	(Maternal / Paternal)
Lazy Eye	□ yes □ no	Relationship:	(Maternal / Paternal)
Macular Degeneration	□yes □no	Relationship:	(Maternal / Paternal)
Color Blindness	a yes a no	Relationship:	(Maternal / Paternal)
Other Vision History		C *00	
Preferred Language: □ English □ Spanish		·	
□ Asian □ African Ameri □ Hispanic □ Native Hawai	ian or Alaskan Na	tive	
Ethnicity:	or Latino ian/ Other Pacific	Islander	•
Communication Prefe □ Email □ Text □ Mail □ Telephone	rence:		
Referred by: Patie	ent:	□ Professional:	Other:
evaluations. A separate condition of the eyes wh Soft contact lens evalua depending on the type of Staff or your Optometric Financial Response	contact lens fee is ille wearing conta- tion and new pre- of soft lens being st for details. sibility & Ber	c charged beyond the comprehens ct lenses. We also evaluate change scription is \$55; refitting to a new fit. The fees for Custom or RGP co	h and safety, we perform annual contact lens five eye examination. We determine fit, health and the es in prescription and lens design during this process. I brand of contact lens will cost between \$85 and \$245 and \$245 and \$245 and \$245 and \$245 and \$250
whether paid by my insu responsible for all charge benefits coverage and it such benefits if they are	rance company. i es whether paid b is my responsibili provided after me	give my permission to bill my insu y my insurance carrier. I understan ty to make that information knowr	urance company with the understanding that I am and that I am responsible for and aware of my eyewear at time of purchase. I understand that I will forfeit ad/or provided. I understand that the fee for returne
Please sign below th knowledge.	at you have re	viewed all of the informatio	on above, and it is correct to the best of your
Signature(Require		Printed Name	Date