Welcome to Our Office

Mr. ☐ **Dr.** ☐
Mrs. ☐ **Ms.** ☐

Patient Information

Today's Date: ___________

Name: ______________________________________ **Date of Birth**: ______________ **Age**: _____
Street Address: ____Social Security #: _________________
City:____State: ______________Zip: _______________
Home #: _______________________Cell #: _______________________ Work #: _________________
Email Address: ____
(Used only to send information and confirming appointments)
Race: _____________ Ethnicity: _________________ Primary Language: _________________________
Employer: _____________________________________ ***Occupation***:_____________________________
Parent/Spouse Name: _________________________________ Phone #: _________________________
Address: ____

VISION PLAN (Circle one): VSP/Nassau County/Davis/Eye Med/ Other: _____________________

Primary **MEDICAL** Insurance Information

Policy holder Name: __________________________ SS#: ___________________ DOB: ______________
Insurance Co: ___________________________________ ID/Policy #: ____________________________
Relationship to patient: __________________ Employer: ____

Secondary Insurance to File

Name: ______________________________________ SS#: _________________ DOB: _____________
Insurance Co: _________________ ID/Policy #: _______________ Relationship to patient: ___________

General Health

Do you have	Y	N	Family	Do you have	Y	N	Family	Do you have	Y	N	Family
Diabetes				Asthma				High Cholesterol			
Hypertension				Cancer				Multiple Sclerosis			
Heart Problems				Blindness				Macular degeneration			
Kidney Problems				Arthritis				Headaches/Migraine			
Thyroid Problems				Other							

Name of PCP: ____ Phone #: ____________________________
Address: ____
Last Eye Exam: _______________________ **Last General Physical Exam**:__________________________
List Medical Conditions for which you are being treated: ____
____
Current Medications:____
____
List all medications you are **ALLERGIC** to: ____
____

PATIENT HISTORY

Vision Correction History (*please check any that apply*)

Amblyopia (Lazy Eye)	☐	Fluctuating vision	☐	Loss of vision	☐
Blurred vision at a distance	☐	Foreign body sensation	☐	Mucous discharge	☐
Blurred vision at near	☐	Halos	☐	Redness	☐
Burning	☐	Regular Headaches	☐	Sandy or gritty feeling	☐
Double vision	☐	Stopped wearing contacts	☐	Sensitivity to light/glare	☐
Drooping eyelid	☐	Stopped wearing glasses	☐	Strabismus (crossed eyed)	☐
Dryness	☐	Infection of eye/lid	☐	Tired eyes	☐
Eye pain/soreness	☐	Itching	☐	Watery eyes	☐
Floaters or spots	☐	Loss of peripheral vision	☐		

Glasses History (*check all that apply)*

What glasses do you own?

				Check any that apply:	
Backup pair	☐	Safety glasses	☐	Allergic to nickel	☐
Bifocals	☐	Single vision	☐	I do not want to wear glasses	☐
Distance	☐	Sports glasses	☐	Incorrect prescription	☐
Progressive lens	☐	Sunglasses	☐	Need spare glasses	☐
Reading	☐	Trifocals	☐	Need sunglasses with UV	☐
				Problems with current glasses	☐
				Problems with glare	☐
				Problems with night vision	☐

How many hours per day do you spend using a computer? ___

Contact Lens History (*check all that apply)*

	Check any that apply:	
What brand of contact do you wear? ________________	I do not wear contacts	☐
How old are your current contacts? _________________	Incorrect prescription	☐
How often do you replace them? ___________________	Interested in refractive laser surgery	☐
What solution do you use for soaking? _______________	Need spare contacts	☐
What is your typical wearing schedule? _______________	Problems with current contacts	☐
	Would like to change my eye color	☐

Referral Info: How did you learn about our office? (*Circle Appropriate Source*)

Relative / Friend/ HMO Ins / Location/ Doctor Referral/ Internet

Family Member who are patients here: ____

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If you are a new patients, who may we thank for referring you? ____________________________