

Welcome to our office!

Please fill out this form as completely as possible and return it to the desk.

Name of Doctor you wish to see:	<input type="text"/>	Today's Date	<input type="text"/>
Name	<input type="text"/>	Email Address	<input type="text"/>
Address	<input type="text"/>	Home Phone	<input type="text"/>
Apt.#	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Cell Phone <input type="text"/>
City	<input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/> Work Phone <input type="text"/>
Date of Birth	<input type="text"/>	SSN <input type="text"/>	Fax Phone <input type="text"/>
Primary Care Physician	<input type="text"/>	Phone	<input type="text"/>
Previous Eye Doctor	<input type="text"/>	Phone	<input type="text"/>
Last Eye Exam	<input type="text"/>	Referred By	<input type="text"/>

Vision Insurance Information

Insurance	<input type="text"/>	Card Number or I.D.#	<input type="text"/>
Cardholder	<input type="text"/>	Group Number	<input type="text"/>
Address	<input type="text"/>	Apt.#	<input type="text"/>
City	<input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/> Date of Birth <input type="text"/>
Relationship to Insured:	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other

Medical Insurance Information

Insurance	<input type="text"/>	Card Number or I.D.#	<input type="text"/>
Cardholder	<input type="text"/>	Group Number	<input type="text"/>
Address:	<input type="text"/>	Apt.#	<input type="text"/>
City	<input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/> Date of Birth <input type="text"/>
Relationship to Insured:	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other
Employer	<input type="text"/>	Sports/Hobbies	<input type="text"/>
Occupation	<input type="text"/>	Emergency Contact	<input type="text"/> Phone <input type="text"/>
<input type="checkbox"/> I wear Glasses <input type="checkbox"/> I wear contact lenses <input type="checkbox"/> Soft <input type="checkbox"/> Hard What brand of contact lens do you currently wear? <input type="text"/>			
Are the contact lenses you are currently wearing comfortable? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Medical History

Allergies		Ocular History	
Medications		Injuries/ Surgeries	

Family Medical History: Note relation to yourself in the box (example: "Mother", "Paternal Grandfather" etc.)

<input type="checkbox"/> Blindness		<input type="checkbox"/> Cancer	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Macular Degeneration		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Retinal Detachment		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Crossed Eyes		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Lupus		<input type="checkbox"/> Thyroid Disease	
Other: <input style="width: 50%;" type="text"/>		<input type="checkbox"/> Currently pregnant or nursing.	

<input type="checkbox"/> Doesn't Drive	<input type="checkbox"/> Drives	<input type="checkbox"/> Doesn't Use Tobacco	<input type="checkbox"/> Uses Tobacco
Driving Difficulties <input style="width: 30%;" type="text"/>	Type/Amount/How Long? <input style="width: 30%;" type="text"/>		

<input type="checkbox"/> Doesn't Drink Alcohol	<input type="checkbox"/> Drinks Alcohol	<input type="checkbox"/> Doesn't Use Illegal Drugs	<input type="checkbox"/> Uses Illegal Drugs
Type/Amt/HowLong <input style="width: 30%;" type="text"/>	Type/Amt/HowLong <input style="width: 30%;" type="text"/>		

Have you ever been exposed to or infected with Gonorrhoea Hepatitis Syphilis HIV

Review of Systems. Please check all that apply to you.

Eyes	<input type="checkbox"/> Flashes	<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Hormonal Dysfunction	Allergic/Immune	Musculoskeletal
<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Floating Spots	<input type="checkbox"/> Fatigue	Respiratory	<input type="checkbox"/> Drug Allergies	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Tired Eyes	<input type="checkbox"/> Trauma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Distorted Vision	<input type="checkbox"/> Cataracts	Integumentary (Skin)	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ankylosing Spond.
<input type="checkbox"/> Dryness	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rosacea	Cardiovascular	Lymphatic/Hematologic	Genitourinary
<input type="checkbox"/> Redness	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Retinal Detachment	Neurologic	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Bladder Problems
<input type="checkbox"/> Gritty Feeling	Gastrointestinal	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Leukemia	<input type="checkbox"/> STD's
<input type="checkbox"/> Itching	<input type="checkbox"/> Colitis	<input type="checkbox"/> Migraines	Ears/Nose/Throat	Please list any other symptoms you may be experiencing.	
<input type="checkbox"/> Burning	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Allergies		
<input type="checkbox"/> Excess Watering	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Mult. Sclerosis	<input type="checkbox"/> Sinus Congestion		
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Constipation	Endocrine	<input type="checkbox"/> Runny Nose		
<input type="checkbox"/> Eye Pain/Soreness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Non Insulin Diabetes	<input type="checkbox"/> Post Nasal Drip		
<input type="checkbox"/> Chronic Infection	Constitutional	<input type="checkbox"/> Insulin Diabetes	<input type="checkbox"/> Chronic Cough		
<input type="checkbox"/> Sties	<input type="checkbox"/> Fever	<input type="checkbox"/> Thyroid Dysfunction	<input type="checkbox"/> Dry Throat/Mouth		