Welcome to our Office!

This information will help us meet our goal of providing you with quality eye care and service.

PATIENT INFORMATION:

First Name:________________________ Last Name:________________________ M☐ F☐ Birth Date:___/__/____

Street Address:____

City:____ State:________________ Zip:__________________

Cell Phone: (___) ___ - ____ Texting: Yes☐ No☐ Home Phone: (___) ___ - ____ Work Phone: (___) ___ - ____

Primary Email Address:____ Social Security No.: _____ - ___ - ______

Employer:____ Occupation:____________________________________

Students: School Attending :____ Grade Level: _______

If Minor: Parent's Name:____ Phone Number: (___) ___ - ____

INSURANCE INFORMATION:

Insurance Plan Name:____ ID #________________________

Primary Name on Insurance:____ Relationship to Patient:_____________

Primary Insured's Date of Birth: ___/__/____ Primary Insured's Phone Number: (___) ___ - ____

PLEASE MARK THOSE THAT MAY APPLY SO THAT WE MAY BETTER SERVE YOU.

MEDICAL HISTORY	Self	Family
Diabetes	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Thyroid Disease	☐	☐
Cancer	☐	☐
Headache/Migraines	☐	☐
Lung Disease	☐	☐

OCULAR HISTORY	Self	Family
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Eye Surgery	☐	☐
Eye Injury	☐	☐
Other________________________________		

MEDICATIONS:______________________________________

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ALLERGIES:____

SOCIAL HISTORY	Yes	No
Tobacco Use	☐	☐
Alcohol Use	☐	☐

Reason for today's visit? ☐ Comprehensive Eye Examination Date of your last exam? __/__/____
☐ Eyeglasses ☐ Contact Lenses
☐ Emergency Visit (specify)____

Currently wearing: ☐ Eyeglasses for: ☐ Distance ☐ Near ☐ Both
☐ Contact Lenses ☐ Daily Wear ☐ Extended Wear
Brand____________________________________ Power: R:_________L:__________

Are you experiencing: ☐ Blurry Vision at: ☐ Distance ☐ Near
☐ Double Vision ☐ Headache ☐ Flashes or Floaters
☐ Tearing ☐ Itching ☐ Discomfort

Pregnant or Nursing? ☐ Yes ☐ No

How did you hear about us? ☐ Internet ☐ Location ☐ Insurance ☐ Christ Fellowship Directory
☐ Referred By:___________________________ ☐ Other:_____________________

Dedicated to *"Enhancing and Preserving the Gift of Sight"*.