PATIENT

I. Patient's Information

Last Name: ____________ First Name: ____________ Middle Initial: ______

Date of Birth: ______ / ______ / ______ (Month / Day / Year) Age: ______ Gender: ☐ Male ☐ Female

Social Security Number: ____ - ____ - ____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: ____________

City: ____________ State: ______ Zip Code: ______

Home Phone: ______ Cell Phone: ______ Email: ____________

II. Insurance Information

Insurance Company: ____________

Policy Holder's Name: ____________ Patient's Relation to Insured: ______

Policy Holder's Date of Birth: ______ / ______ / ______ (Month / Day / Year) Social Security Number: ____ - ____ - ____

III. Guarantor (if patient is a dependent)

Last Name: ____________ First Name: ____________ Middle Initial: ______

Date of Birth: ______ / ______ / ______ (Month / Day / Year) Age: ______ Gender: ☐ Male ☐ Female

Social Security Number: ____ - ____ - ____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: ____________

City: ____________ State: ______ Zip Code: ______

Home Phone: ______ Cell Phone: ______ Email: ____________

IV. Patient's Employment Information (Occupation)

Employer/School: ____________ Work Phone #: ______

Address: ____________

City: ____________ State: ______ Zip Code: ______

Do you or Anyone in Your Immediate Family Have Any History of the Following? If yes, please check the box.

Condition			Condition			Condition		
Glaucoma	☐ Self	☐ Family	Heart Disease	☐ Self	☐ Family	Thyroid	☐ Self	☐ Family
Cataract	☐ Self	☐ Family	High Blood Pressure	☐ Self	☐ Family	Arthritis	☐ Self	☐ Family
Macular Degeneration	☐ Self	☐ Family	High Cholesterol	☐ Self	☐ Family	Headache	☐ Self	☐ Family
Retinal Detachment	☐ Self	☐ Family	Respiratory	☐ Self	☐ Family	Lupus	☐ Self	☐ Family
Red Eyes:	☐ Self		Eye Injuries	☐ Self		Kidney	☐ Self	☐ Family
Dry Eyes:	☐ Self		Watery Eyes:	☐ Self		Diabetes	☐ Self	☐ Family
			Itchy Eyes:	☐ Self				

Do you smoke? ☐ Yes ☐ No

List Any Medications That You Are Allergic To: ____________

____

Please List ALL Current Medications: ____________

____

Please List ALL Major Surgery (Eye Surgery Included): ____________

____

HOW DID YOU HEAR ABOUT US? ____________