PATIENT INFORMATION FORM

First:_____Middle:_____ Last:_____ Date: _____

Address:_____

City:_____ State:_____ Zip: _____

*Primary Phone Number:_____ ❒ Home ❒ Cell ❒ Work ❒ Caregiver

Secondary Phone Number:_____ ❒ Home ❒ Cell ❒ Work ❒ Caregiver

*The Primary Phone Number will be used for all calls, including appointment confirmations.

Date of Birth:_____ Occupation: _____

Sex: ❒ Male ❒ Female Social Security #:_____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Domestic Partner

Employed: ❒ Full Time ❒ Part Time ❒ Retired Student: ❒ Full Time ❒ Part Time ❒ None

Employer: _____ Phone: _____

Parent's Employer (if applicable): _____ Phone: _____

Do you live in a nursing home or hospice: r Yes r No Do you speak English? ❒ Yes ❒ No

Emergency Contact (Not living with you):_____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician:_____ Phone: _____

If different from Patient, Person Responsible for Payment:_____

Date of Birth: _____ Social Security #:_____Relationship:_____

Address: _____ Phone: _____

City:_____ State:_____ Zip: _____

How did you hear about us? _____

INSURANCE

Primary Insurance:_____ ID#: _____

Group #:_____ Subscriber Name: _____ Date of Birth: _____

Employer:_____ Phone: _____

Secondary Insurance:_____ ID#: _____

Group#:_____ Subscriber Name: _____ Date of Birth: _____

Employer:_____ Phone: _____

Other Insurance Coverage for Routine Vision Care Only? Yes No

Vision Insurance Carrier _____

Phone Number _____

Policy Holder/Subscriber Date of Birth_____/_____/_____

Employer Relationship to Patient _____

PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

When was your last eye exam? _____ Prior eye doctor: _____

Current occupation: _____

Do you use a computer? __ Yes __ No How many hours per day? _____ Distance from monitor:_____

Do you drive? __ Yes __ No Do you have glare or night driving problems? __ Yes __ No

SPECTACLE LENS HISTORY

Do you currently wear glasses? __ Yes __ No Since: _____
Type of glasses: __ Full Time __Part Time __ Distance __ Reading/near

Glasses owned: __ Single Vision __ Bifocals __ Trifocals __ Progressive __ Backup
__Safety __ Sports __ Transitions

Have you had trouble in the past with glasses? __ Yes __ No (Explain):_____

Do you wear sunglasses? __ Yes __ No Are your sunglasses your current prescription? __ Yes __ No

CONTACT LENS HISTORY

Do you currently wear contact lenses? __ Yes __ No Since: _____

Have you ever been unsuccessful with contact lenses? __ Yes __ No Reason for stopping: _____

Type/Brand of CL: _____ Average wear time: ____ hrs/day

How many days per week do you wear them? _____ How often do you replace them? _____

Which solution(s) do you use to clean your lenses? _____

If you know, please complete the following information:

	Power	BC	Diameter
Right (OD):	_____	_____	_____
Left (OS):	_____	_____	_____

If not a contact lens wearer, are you interested in trying contact lenses at this time?_____

SOCIAL HISTORY

Do you engage in regular exercise? __ Yes __ No

Do you drink alcohol? (If yes, how much?) __ No __ Occasionally __ 1 glass per day __ 2-3 per day __ 4+ per day

Do you smoke? (If yes, how much/often?) __ No __ Occasionally Pack/Day _1 _2 _3

Hobbies/Interests: _____

SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, anti-glare, tints, or coatings)

Occupational (mechanics, plumbers, pilots, electricians)

Safety Glasses (gardening, woodworking, welding)

Sports/ Hobbies (racquet sports, motorcycle)

FOR OFFICE USE ONLY

Initials: _____	Date: _____	Initials: _____	Date: _____	Initials: _____	Date: _____
Initials: _____	Date: _____	Initials: _____	Date: _____	Initials: _____	Date: _____
Initials: _____	Date: _____	Initials: _____	Date: _____	Initials: _____	Date: _____