Submit as Guest → Print Form

Patient Form

Complete and submit this form before your appointment.

Basic Information

To 'Submit' form, all required fields in this section must be filled out.

First Name * | MI | Last Name * | Sex * (Male / Female)

Date of Birth * (MM/DD/YYYY) | Age 0 | Marital Status * | SSN Last 4 * (XXXX)

Street Address/PO Box * | City * | State * | Zip *

Employment Status | Occupation | Allow Messaging (Home / Text / Email)

To 'Submit' form, please enter at least one method of contact.

Home Phone (XXX) XXX-XXXX | Cell Phone (XXX) XXX-XXXX | Email Address

Employer Info

Employer Name | Phone (XXX) XXX-XXXX

Street Address/PO Box | City | State | Zip

Other Contact Info

Person responsible for charges (Add if not patient) | Relationship to Patient | Phone (XXX) XXX-XXXX

Emergency contact | Emergency contact relationship | Phone (XXX) XXX-XXXX

Visit Information

Last eye exam date MM/DD/YYYY | First Visit ○ Yes ○ No

Reason for current visit | Referred by

Eye Health *Check all that apply*

- ☐ Amblyopia
- ☐ Blurred Vision - Far
- ☐ Blurred Vision - Near
- ☐ Burning Eyes
- ☐ Cataracts
- ☐ Double/Distorted Vision
- ☐ Drooping Eyelid
- ☐ Dry Eyes
- ☐ Eye Surgeries
- ☐ Eye Turn
- ☐ Floaters/Spots
- ☐ Fluctuating Vision
- ☐ Foreign Body Sensation
- ☐ Glaucoma
- ☐ Glare/Light Sensitivity
- ☐ Headaches
- ☐ Itchy Feeling
- ☐ Infection of eye/lid
- ☐ Loss of Vision - Central
- ☐ Loss of Vision - Side
- ☐ Mucus/Discharge
- ☐ Redness
- ☐ Retinal Detachment
- ☐ Tearing/Watery Eyes

General Health *Check all that apply*

- [ ] Allergies/Hay Fever
- [ ] Asthma/Respiratory
- [ ] Blood Disorders
- [ ] Cancer
- [ ] Cardiovascular/High BP
- [ ] Chronic Bronchitis
- [ ] Chronic Cough
- [ ] Diabetes
- [ ] Emphysema
- [ ] Gastrointestinal Problems
- [ ] Heart Attack/Strokes
- [ ] Headaches/Migraines
- [ ] Kidney Disease
- [ ] Psychiatric Depression
- [ ] Rheumatoid Arthritis
- [ ] Thyroid/Endocrine Disease
- [ ] Skin Disorders
- [ ] Weight Loss/Gain

Do you smoke tobacco products?

- ( ) Yes, I smoke everyday
- ( ) Yes, I smoke occasionally
- ( ) No, I'm a former smoker
- ( ) No, I've never been a smoker

Family History - Blood Relatives *Check all that apply*

- [ ] Amblyopia
- [ ] Blurred Vision - Far
- [ ] Blurred Vision - Near
- [ ] Burning Eyes
- [ ] Cataracts
- [ ] Double/Distorted Vision
- [ ] Drooping Eyelid
- [ ] Dry Eyes
- [ ] Eye Surgeries
- [ ] Eye Turn
- [ ] Floaters/Spots
- [ ] Fluctuating Vision
- [ ] Foreign Body Sensation
- [ ] Glaucoma
- [ ] Glare/Light Sensitivity
- [ ] Headaches
- [ ] Itchy Feeling
- [ ] Infection of eye/lid
- [ ] Loss of Vision - Central
- [ ] Loss of Vision - Side
- [ ] Mucus/Discharge
- [ ] Redness
- [ ] Retinal Detachment
- [ ] Tearing/Watery Eyes

Physician / General Practitioner

Physician Name

Phone (XXX) XXX-XXXX

Last Medical Exam Date MM/DD/YYYY

Medications *Enter all medications taken, and for which condition each is taken*

	Medication	Condition
1		

2

3

4

5

6

7

8

Allergies *Enter all medications or substances to which the patient is allergic*

Please answer the following questions

Are you pregnant or nursing?

Yes No

Do you have trouble driving at night?

Yes No

Do you wear glasses?

Yes No

Do you wear contacts?

Yes No

Do you experience blur, headaches, or eyestrain with computer use?

Yes No

Are you interested in laser (refractive) surgery to correct your vision?

Yes No

Vision Insurance Information

Insurance Company | ID Number | Group Number

Patient's relationship to insured

Self Spouse Child Other

Primary Insured's Sex

Male Female

Name of the Insured | Insured's Phone Number | Insured's Date Of Birth

(XXX) XXX-XXXX

MM/DD/YYYY

Other Insurance Information

Insurance Company | ID Number | Group Number

Patient's relationship to insured

Self Spouse Child Other

2nd Insured's Sex

Male Female

Name of the Insured | Insured's Phone Number | Insured's Date Of Birth

(XXX) XXX-XXXX

MM/DD/YYYY

Additional Comments *Is there anything else we should know? Let us know below.*