

New Patient Info

*Starred fields required

*First Name: _____

*Last Name: _____

*Date of Birth: ___/___/_____

*Patient's Last 4 digits of SSN#: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

*Mobile Phone #: (____) - ____ - _____

Home Phone #: (____) - ____ - _____

*Email Address: _____

*Race:

- Declined to Specify American Indian or Alaska Native Asian
 Black or African American Native Hawaiian or Other Pacific Islander White

*Ethnicity:

- Declined to Specify Hispanic or Latino Non-Hispanic or Latino

*Name of Vision Insurance:

- EyeMed VSP

Medical Insurance

*Insurance Name: _____ *Member ID #: _____

Guarantor Name: _____ Guarantor Date of Birth: ___/___/_____

Guarantor Last 4 Digits of SSN#: _____

**PHARMACY
INFO**

NAME: _____

ZIPCODE: _____

ADDRESS: _____

PHONE: _____

**MEDICAL
HISTORY**

Do you have or
have you had

- NONE Arthritis Hypertension (High Blood Pressure) Hyperthyroidism
- Asthma Hypercholesterolemia (Cholesterol) Hypothyroidism
- Diabetes Type 1 or 2 Stroke Other: _____

CANCER TYPE: _____

PAST SURGERY: _____

DATE: _____

**OCULAR
HISTORY**

Do you have or
have you had

- NONE Cataract R / L Glaucoma R / L Strabismus (Eye Turn) R / L
- Contacts R / L Macular Degeneration R / L Other Eye Condition: _____
- Glasses R / L Retinal Tear R / L Other Eye Condition: _____

PAST EYE SURGERY: _____

DATE: _____

**CURRENT
MEDICATIONS**

- NONE
- SEE ATTACHED LIST

NAMES & DOSAGES OF MEDICATIONS

ALLERGIES

TO MEDICATIONS: NONE

NAME OF MEDICATIONS:

REACTION:

OTHER ALLERGIES: NONE

**SOCIAL
HISTORY**

- SMOKING NEVER FORMER SMOKER CURRENT, EVERY DAY CURRENT SOME DAYS
- ALCOHOL NEVER LESS THAN 1 DRINK / DAY 1-2 DRINKS / DAY 3 OR MORE DRINKS/DAY

**FAMILY
HISTORY**

- Macular Degeneration / Relation: _____ Coronary Artery Disease / Relation: _____ Other: _____ / Relation: _____
- Glaucoma / Relation: _____ Stroke / Relation: _____ Other: _____ / Relation: _____
- Retinal Detachment / Relation: _____ Diabetes Type 1 or 2 / Relation: _____ None
- Atrial Fibrillation or Irregular Heartbeat Relation: _____
- CANCER: Type: _____ Relation: _____ Type: _____ Relation: _____

**REVIEW OF
SYSTEMS**

Are you
experiencing

- Poor Vision Tearing Seeing Floaters Congestion Headaches
- Double Vision Eye Redness Weight Loss Shortness of Breath Other: _____
- Eye Pain See Flashing Lights Rapid Heartbeat Dry Mouth Other: _____