

Today's Date: _____
Month / Day / Year

Date of last eye exam _____
Month / Day / Year

Patient Information (Please Print):

Patient's Name _____, _____
Last First M.I.

Home Address _____

City, State, Zip _____

Patient's Social Security Number _____

Employer _____

Medical Insurance _____

Insured's Name _____, _____
Last First

Vision Insurance _____

Insured's Name _____, _____
Last First

How did you hear about our office: _____

Family Information: Spouse _____ Children _____ Patients in our office? Y / N

Are you interested in learning about Children and Infant Vision? Y / N Are you interested in Laser Vision Correction? Y / N

Family Medical History (Please circle yes or no, if not answer it will be assumed no.)

Arthritis	No	Yes	Maternal	Paternal	Glaucoma	No	Yes	Maternal	Paternal
Cancer	No	Yes	Maternal	Paternal	Cataracts	No	Yes	Maternal	Paternal
Diabetes	No	Yes	Maternal	Paternal	Eye Disease	No	Yes	_____	_____
High Blood Pressure	No	Yes	Maternal	Paternal	Eye Surgery	No	Yes	_____	_____
Retinal Detachment	No	Yes	Maternal	Paternal	Other	No	Yes	_____	_____
Macular Degeneration	No	Yes	Maternal	Paternal	Other	No	Yes	_____	_____

Personal Medical History (Please circle yes or no, if not answer it will be assumed no.)

Name of Family Doctor _____

Date of last visit _____

Do you have any problems with any of these systems?

Allergic/Immunologic	No	Yes	Glaucoma	No	Yes
Blood/Lymph	No	Yes	Cataracts	No	Yes
Cardiovascular	No	Yes	Dry Eyes	No	Yes
Cancer	No	Yes	Macular Degeneration	No	Yes
Diabetes	No	Yes	Retinal Detachment	No	Yes
Endocrine	No	Yes	Eye Injury	No	Yes
High Blood Pressure	No	Yes	Eye Surgery	No	Yes
Respiratory	No	Yes	Allergies to Medication	No	Yes

Current Medications (name/dosage/year started)

Antihistamines	_____
Diuretics	_____
Blood Pressure	_____
Diabetes	_____
Cholesterol	_____
Birth Control	_____
Other	_____

If YES to any above, please explain _____

List any complaints about your eyes, glasses, or contacts: _____

Do you have more than one pair of glasses?	No	Yes	Do you work on the computer at work?	No	Yes
Would you like information on lighter, thinner lenses?	No	Yes	Are there times you'd rather not wear glasses?	No	Yes
Do you play sports, swim, or enjoy outdoor activities?	No	Yes	Are you happy with your current contacts?	No	Yes
Do you experience any headaches or eyestrain?	No	Yes	Do you see floaters or flashes of light?	No	Yes
Are your eyes dry and itchy during the day?	No	Yes	Are you sensitive to light and the sun?	No	Yes

By signing below, I acknowledge that I have read and was given a copy of 20/20 Optometry Notice of Privacy Practices that is valid for 6 years. I certify that I have read and understood the above information and the questions have been answered accurately. I realize that inaccurate answers may affect my health. I understand that my insurance information may be obtained or submitted electronically or by fax if order to receive authorization or payment. I authorize the doctor to release any records including the diagnosis and treatment rendered to me or my child. I request my insurance company pay directly to the above eye doctor or group. I understand that my insurance may pay less than the stated amount. I will be responsible for the balance of all services and products rendered to myself and/or my family. If in the event any collections or disputes, I agree to pay for all court costs and late charges.

Signature of Patient or guardian: _____