PATIENT INTAKE FORM

Demographics

First Name _____ Last Name _____ MI _____ Suffix _____

Preferred Name/Nickname _____

Home Address: _____ Apt/Suite # _____

City _____ State _____ Zip Code _____

Cell Phone: _____ Work Phone: _____

Email: _____ Preferred Contact Method: O cell phone O email

SSN: _____-_____-_____ (optional, but often needed to authorize insurance benefits)

Sex(circle): Male Female Other:_____ Birthday ___/___/___ Occupation:

_____

Preferred Pharmacy: _____ Phone Number: _____

Billing Information: O Same as above

First _____ Last _____ MI _____ Suffix _____

Address _____ Apt/Suite #

City _____ State _____ Zip Code:

Home Phone _____

Work Phone _____

Insurance Information

(You do not need to fill this out if it is already on file with our front office)

Vision Insurance:

Insurance Name _____

Insurance ID Number: _____

Insurance Group Policy Number (if applicable):_____

Medical Insurance:

Insurance Name _____

Insurance ID Number: _____

Insurance Group Policy Number (if applicable):_____

Other Insurance:

Insurance Name _____

Insurance ID Number: _____

Insurance Group Policy Number (if applicable):_____

Are you the Primary on the account: O Yes O No

If no, please fill out the information below:

Name of Primary: _____

Relation to insured: O Spouse O Child O Other

Sex: O Male O Female O Other_____

Address: O Same as above

Address: _____ Apt/Suite # _____

City _____ State _____ Zip Code: _____

Birthday _____

SSN: _____-_____-_____

Employer/School: _____

Medical History

Main Reason for Today's Visit: _____

Primary Care Provider: Name _____ Phone Number _____

Have you had an eye injury or been diagnosed with cataracts, lazy eye, retinal problems, or glaucoma (if yes, please list below):

_____

Does anyone in your family have/had Glaucoma? Macular degeneration? Retinal detachment? Other Retinal Disorders? (If yes, please list below)

_____

Do you have a history of headaches? Arthritis? Asthma? Diabetes? Blood pressure? Heart Problems? Inflammatory Bowel Disease? Seizures? Thyroid Problems? Or other medical conditions (if yes, please list below):

_____

_____

Does anyone in your family have/had Diabetes? Lupus Cancer? High Blood Pressure? Heart Problems? Auto-immune disease? Or other medical conditions? (if yes, please list below)

_____

_____

Medications (including OTC meds, and eyedrops): O No current medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to medications: O No known Drug Allergies

_____

Smoking Status: O Every Day Smoker O Some Day Smoker O Former Smoker O Never Smoker

Are you pregnant, nursing, or HIV+? (if yes, please list below)

_____

Any Other Relevant Information?

_____

Patient Signature: _____ Date: _____