Patient Name_____ **Date** _____/_____/_____
Last First MI

Address_____ Apt_____ City_____ State____
Zip_____ Male_____ Female_____ Married_____ Single_____ Other_____

Date of Birth _____/_____/_____ Social Security # _____

Phone # (H) _____ (W)_____ (Mobile)_____

Email Address: _____ Occupation_____

Were you referred to us? Y N If yes, by whom or where? _____

Primary Medical Insurance Plan: _____ **Plan ID #**_____

Insureds Last Name_____ MI_____ First Name_____
Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insureds Address_____ Apt_____ City_____
State_____ Zip_____ Male_____ Female_____ Date of Birth _____/_____/_____

Social Security # _____ **Do you have secondary/tertiary medical insurance** p**lans?** Y N

Vision Insurance Plan: _____ **Plan ID #**_____

Vision Insureds First Name_____ MI_____ Last Name: _____
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insureds Address_____ Apt_____ City_____
State_____ Zip_____ Male_____ Female_____ Date of Birth _____/_____/_____

Are you interested in wearing contact lenses? Y N
If you wear contact lenses, what is the prescription and the brand? _____

Please list any medications you are taking (include birth control): _____

_____

Please list any medical conditions you may have: _____

List any allergies: _____
Have you ever noticed or experienced? (Circle all that apply):

Flashes of light Floaters Double Vision Redness in eyes Burning tearing Eye Injury

Eye Discharge Blurring Itching in Eyes Surgery? (List) _____

_____

Indicate if you or any family member has the following, indicating which family member:
Glaucoma_____ Cataracts_____ Eye Turn_____ Blindness_____
Eye Disease_____ Macular Degeneration_____ Diabetes _____
Hypertension_____ Heart Disease_____
Are you interested in Laser Vision Correction? Y N