

# Patient Information Sheet

Date \_\_\_\_\_  
Patient Name \_\_\_\_\_ Home phone \_\_\_\_\_  
Social Security # \_\_\_\_\_  Male  Female Cell phone \_\_\_\_\_  
Address \_\_\_\_\_ Birthday \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_  
(Check appropriate box)  Minor  Single  Married  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Vision Insurance \_\_\_\_\_  
Insurance Holder/Parent/Guardian \_\_\_\_\_ Insured's SS # \_\_\_\_\_  
Insured's Birthday \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_

Please circle the following information if it applies to you.

## Ocular Information

Do you have any problems with your vision? **YES** **NO**

Explain, \_\_\_\_\_

Date of last Exam? \_\_\_\_\_

Who is your doctor? \_\_\_\_\_

Were your eyes dilated? **YES** **NO**

Dilation is highly recommended for patients over 40, or have a medical condition that can affect the health of the eye.

Would you like to be dilated today? **YES** **NO**

Do you wear glasses now? **YES** **NO**

Do you wear contacts? **YES** **NO**

If yes prescription renewal needed? **YES** **NO**

If no, are you interested in contacts? **YES** **NO**

Do you have any of the following eye conditions?

Glaucoma          Amblyopia (lazy eye)

Cataracts          Eye Surgery

Others: \_\_\_\_\_

Please Circle the following information if it applies to you.

## Medical History

When was you last physical exam? \_\_\_\_\_

Who is your primary care doctor? \_\_\_\_\_

Are you taking any medications? **YES** **NO**

Yes, please list \_\_\_\_\_

Are you allergic to any medications? **YES** **NO**

If yes, list \_\_\_\_\_

Do you have, or have you had any of the following conditions?

Diabetes **YES** **NO** How Long? \_\_\_\_\_

High Blood pressure **YES** **NO** How Long? \_\_\_\_\_

Other medical conditions: \_\_\_\_\_

## Family History

Do you have a family history of any of the following conditions?

Diabetes **YES** **NO** Who? \_\_\_\_\_

High Blood Pressure **YES** **NO** Who? \_\_\_\_\_

Glaucoma **YES** **NO** Who? \_\_\_\_\_

Others: \_\_\_\_\_

## Authorize, Release, And Acknowledge

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly or to the doctor. Eye ware is custom ordered. There will be no refunds for services or products. Orders not picked up within 60 days will be returned and deposits will be lost. Diagnostic medical testing done in office, will be filed under your medical insurance. Amounts not paid by insurance are the patients responsibility. I also acknowledge that Eyedeals Optometry's Notice of Privacy Practice is available for me to read in the waiting room at any time and copies will be given upon request.

Signature of Patient (or parent/ guardian if minor) \_\_\_\_\_