Welcome to Our Office
Advanced Eye Care & Optical

PATIENT INFORMATION

Please Complete All Questions, Check and Sign

Please Print Appointment Date________________________

Name____(Nickname) ___________________________S.S.#___________________________
First M.I. Last

Street Address_________________ ___________________________________City_________________________State__________Zip_________________

Preferred Phone_________________________ Alternate Phone__________________________ May We Text You? Y or N

Date of Birth_____/_____/______ Age_______ Sex_______ Martial Status_________ Email Address____

Employer______________________________ Occupation_____________________ Vision Ins.________________________ID#________________________

Medical Ins.___________________________ ID#______________________ Primary Holder's Name______________________________D.O.B___/___/_____

Primary Holder's S.S#_____________________Pharmacy ______________________ Location_________________________ Phone____________________

Emergency Contact Name _______________________________________ Relationship_____________________________ Phone_________________________

Date of Last Eye Exam____/____/_____ Name of Previous Eye Doctor (if new to office)____

Do you use: ____Glasses____ Contacts? Do you want new _____Contacts_____ Glasses, for _____Regular use____ Reading ____ Computer ____Sports

Do you have a specific visual problem or need?____

Please check any condition(s) which apply to your health:
[ ] No current Health Problems [ ] Anemia[ ] AIDS / HIV [ ] Anxiety [ ] Arthritis [ ] Asthma [ ] Allergies [ ] Crohn's [ ] Cancer[ ] Diabetes
[ ] Depression[ ] Lupus [ ] Thyroid [ ] Heart [ ] High Blood Pressure [ ] High Cholesterol [ ] Kidney Disease[ ] Head Trauma [ ] Headaches

[ ] Weight gain/loss [ ]Pregnant/Nursing [ ] Other____

Please list any surgeries____

Please check any condition(s) that apply to your eye health:
[ ] Contact Lens Wearer[ ] Previous Eye Surgery[ ] Cataracts[ ] Dry Eyes[ ] Blurred Vision (distance / near) [ ] Retinal Detachments
[ ] Lasik / RK Surgery[ ] Lazy Eye[ ] Blind Spot[ ] Floaters [ ] Glaucoma[ ] Eye Allergies[ ] Eye Turn[ ] Flashes[ ] Double Vision[ ] Iritis
[ ] Eye Injury [ ] Red Eyes[ ] Light Sensitivity[ ] Macular Degeneration[ ]Other____

Please list any eye surgeries____

Please check any condition(s) that may have existed in your family:
[ ] Glaucoma[ ] Diabetes[ ] Cataracts[ ] Eye Cancer[ ] Lazy Eye[ ] Retinal Detachment[ ] Lazy Eye[ ] Migraine Headaches[ ] Macular Degeneration

[ ] Other____

Tobacco Use_____Yes _____No if yes, how much___________________________________ number of years__________

Alcohol Use _____None _____Social _____More than 1-2 glasses per day Recreational Drug Use ______Yes ______No

Medications (list all medications you take including over the counter, vitamins, supplements, oral contraceptives):
____

____

Please list any drug allergies: ____

Patient/Guardian Signature: ____ Signed Date: ___________________________