PATIENT INFORMATION

NAME _____ TODAY'S DATE _____ DATE OF BIRTH_____

ADDRESS _____CITY_____STATE _____ZIP_____AGE_____

HOME PHONE _____WORK PHONE_____

SEX M ___ F ____ OCCUPATION _____ HOBBIES _____

MARITAL STATUS S ___ W __ D ___ M _____ EMAIL _____

SPOUSE'S NAME _____ SS # _____ DOB_____

REASON FOR TODAY'S VISIT (Check all that apply) EYE EXAM _____CONTACT LENS EXAM _____

NEW GLASSES ____ OTHER (please explain) _____

CONTRACT HOLDER INSURANCE INFORMATION

MEMBER'S NAME _____EMPLOYER_____INSURANCE GROUP_____

MEMBER'S SOCIAL SECURITY # _____MEMBER'S DATE OF BIRTH _____

MEMBER'S HOME PHONE _____MEMBER'S WORK PHONE _____

MEDICAL HISTORY

When was your last eye exam? _____yrs. Contact fit? _____yrs

Are you taking any medication? Please list, including birth control pills_____

Please list known medical allergies:

_____

_____

Please check any of the following that apply to you (if pertains to a family member, use the appropriate initial: M=mother, F=father, B=brother, S=sister, GP=grandparent, C=children)

___ glaucoma	___eye irritations	___kidney disease	___arthritis	___cataracts
___ flashes of light	___ thyroid disease	___ cancer	___eye injury	___ spots in vision
___ heart disease	___ color blindness	___ eye surgery	___ eye infection	___high blood pressure
___diabetes	___sickle cell disease	___headaches	___sarcoid	___lazy eye (amblyopia)

___ contact lens complications ____ other (explain) _____

I have received a copy of Morris Avenue Eyecare's privacy policy.

Date _____

Signature _____