Screening Photo:
☐ Yes ☐ No

Patient Information Form

Please complete and return this form as soon as possible

Appointment Time:
M

First Name	Mid.	Last Name	Preferred Name	Birth Date

Street Address	City	State	Zip Code

SSN	Marital Status	Sex	Email Address

We respect your privacy, and any contact information given to the office will never be shared. We may contact you for Appointments, Order Status, and occasional Marketing Communications.

Home Phone	Cell Phone	Contact Methods
		Home Y / N Cell Y / N Work Y / N TXT Y / N Email Y / N

Employer	Work Phone	Occupation

Person Responsible for Charges (if not patient)	Relationship to Patient	Phone Number

First Visit?	Referred By (Patient Name, Phone Book, Internet, Insurance Listing, etc...)
Y / N	

Race (circle your answer)	Ethnicity	Pref.Language
American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other Race	Hispanic or Latino Not Hispanic or Latino	

Primary Insurance Company	Insured First Name	Insured Last Name

Insured Identification Number	Insured Date of Birth	Pat. Relation to Insured

Secondary Insurance Company	Insured First Name	Insured Last Name

Insured Identification Number	Insured Date of Birth	Pat. Relation to Insured

Primary Medical Doctor	Doctor's Phone #	Practice Location

Reason For Today's Visit

General Health - Patient (check all that apply)

- ☐ Allergies / Hay fever
- ☐ Asthma / Respiratory
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Cardiovascular / High B.P.
- ☐ Chronic Bronchitis/Cough
- ☐ Diabetes
- ☐ Emphysema
- ☐ Gastrointestinal Problems
- ☐ Heart Attack / Stroke
- ☐ Headaches / Migraines
- ☐ Kidney Disease
- ☐ Pregnant
- ☐ Psychiatric / Depression
- ☐ Rheumatoid Arthritis
- ☐ Thyroid / Endocrine Disease
- ☐ Skin Disorders
- ☐ Weight Loss / Gain

Family Health History (circle all that apply)

☐ **Unknown For All**

Cancer

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Diabetes

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Hypertension

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Cataracts

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Macular Disease (Degeneration)

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Glaucoma

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Current Medications and Condition Being Treated

☐ **No Current Medications**

Medication	Condition	Medication	Condition

Allergies - Medicinal and Environmental

☐ **No Known Allergies**

Medicinal Allergy	Allergic Response	Environmental Allergy	Allergic Response

Smoking Status: (circle your answer)

Never Smoked Former Smoker Unknown
Current Smoker - Daily Current Smoker - Occasional

Alcohol Use:

Y / N **Every** Day Week Month

ver 9.2014