Welcome to Image Eyecare

(PLEASE PRINT)

Patient's Name_____ Dr./Mr./Mrs. Ms./Miss (circle one) Today's Date _____/_____/_____
First Middle Initial Last

Address_____ City_____ State_____ Zip_____

Communication Preference: **Phone** **Postal** **Email** **Text** E-Mail Address _____

Cell Phone (_____)_____ Other Phone (_____)_____

Date of Birth _____/_____/_____ Age_____ Sex: **M / F** Height_____ Weight_____

Race _____ Ethnicity _____ Preferred Language_____

Vision Insurance **Yes / No** Plan Name_____ Medical insurance **Yes / No** Plan Name _____

Social Security Number_____ Occupation_____ Employer_____

Are you interested in learning more about our CareCredit healthcare financing program? **Yes / No**

Do you use a computer? **Yes / No** How many hours a day? _____

What hobbies or sports do you participate in? _____

Have you been a patient in this office before? **Yes / No** How did you hear about us? _____

Date of last Eye Exam_____/_____/_____ Date of last Physical Exam_____/_____/_____

Do you use cigarettes / tobacco? **Yes / No** If female, are you pregnant or nursing? **Yes / No**

What is the main reason for today's visit? _____

_____

Describe any EYE or VISION problems you experience (Blurred Vision, Eye Pain, Double Vision, Flashes, Floaters, Dryness, Allergies)

_____

Do you wear GLASSES? **Yes / No** CONTACT LENSES? **Yes / No** Are you interested in trying contact lenses? **Yes / No**

List any previous **EYE Injuries, Diseases, or Surgeries** _____ None___

List ANY medications you currently take (including birth control or vitamins): _____None___

_____

_____

List ANY medications you are allergic to_____ None___

Have you, or any of your immediate family, had any of the following? (Check all that apply. Check here if none apply__)

Self	Family		Self	Family		Self	Family		Self	Family	
☐	☐	Turned or Lazy Eye	☐	☐	Arthritis	☐	☐	Sinus Problems	☐	☐	Urinary Tract Disease
☐	☐	Cataract	☐	☐	Cancer	☐	☐	Ear Infections	☐	☐	Anxiety
☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐	Autoimmune Disease	☐	☐	Depression
☐	☐	Macular Degeneration	☐	☐	Lupus				☐	☐	Skin Condition
☐	☐	Retina Problems	☐	☐	Stroke	☐	☐	Blood Disorder / Anemia	☐	☐	Stomach
☐	☐	Diabetes	☐	☐	Thyroid Disease				☐	☐	Bowel
☐	☐	High Blood Pressure	☐	☐	Asthma	☐	☐	Headaches	☐	☐	Neurological Disease
☐	☐	High Cholesterol	☐	☐	COPD	☐	☐	Seizures	☐	☐	Other Medical Condition
☐	☐	Heart Disease	☐	☐	Allergies	☐	☐	HIV or other STD			

* Please explain _____

INFORMATION RELEASE CONSENT and FINANCIAL RESPONSIBILITY

I authorize any holder of my personal medical/optical information to release information about me to Image Eyecare and I authorize Image Eyecare to release medical/optical information about me to other healthcare providers, attorneys, or insurance companies in compliance with all HIPPA or other legal requirements.

Responsible Party (Please Print)_____

Signature_____Date_____

All patients are responsible for payment at time of service.