Please Print

Date_____

Patient Name_____ Sex □F M□ Age_____ Date of Birth_____/_____/_____

Social Security# _____-_____-_____ Email Address_____

□ Single □ Married □ Domestic Partner □ Divorced □ Widowed

If Married, Spouse's Name _____Spouse's SS#_____-_____-_____ Spouse's DOB_____/_____/_____

If Child, Parent's name _____Parent's SS#_____-_____-_____ Parent's DOB_____/_____/_____

Address_____ City_____ State_____ Zip Code _____

Primary Phone#(_____)_____-_____ □Cell □Home □Other Secondary Phone#(_____)_____-_____□Cell □Home □Other

Place of Employment/ School_____ Occupation_____

Does your work require special vision needs?_____ If yes, please explain_____

Medical Insurance_____ Member ID#_____ Vision Insurance_____

Date of Last Exam_____ Where_____ Doctor_____

Do you wear contact lenses? □Yes □No Type_____ Are you interested in wearing contact lenses? □Yes □No

Reason for Today's Visit_____

List Activities/ Hobbies_____

How were you referred to our office?_____

Medical History

Medical Doctor_____ Last Visit_____

Do you have? **□ I Have No Medical Conditions** Do you: □ Smoke □Drink □Use Drugs

□ Heart Disease □ Cancer □ Allergies/Sinus Problems **Medications: □None_____**

□ Diabetes □ Thyroid Problems □ Headaches _____

□ High Blood Pressure □ Lung Disease □ Pregnant □Nursing _____

□ High Cholesterol □ Kidney Disease □ Surgery_____ **Allergies**: □None_____

□ HIV □ Asthma □Other_____ _____

Does Anyone in Your Family Have? **□ I Have No Family History of Medical Conditions**

□ Diabetes □ Cancer □ High Blood Pressure

□ Heart Disease □ Lung Disease □Other_____

Ocular History

Do You Have? **□ I Have No Ocular Conditions**

□ Glaucoma □ Blurred Vision □ Eye Watering □ Eye Trauma_____

□ Cataracts □ Double Vision □ Eye Redness □ Eye Turn or Lazy Eye

□ Macular Degeneration □ Flashes □ Eye Itching □ Eye Surgery (Lasik, PRK, etc.)_____

□ Blindness □ Floaters □ Eye Fatigue □ Other Eye Disease_____

Does Anyone in Your Family Have? **□ I Have No Family History of Ocular Conditions**

□ Glaucoma □ Cataracts □ Macular Degeneration □ Blindness □Other_____

I understand it is policy of this office to require:

1) Payment in full or at least one half before an order can be placed.
2) The balance of the fee be paid at the time the order is dispensed.
3) All orders are final when placed.

Record Retention Policy

We are informing you that our office will keep your records for up to 5 years from the date of this examination. If signing for a minor, please be aware that our office will only keep your childs records for 5 years from the date of this examination.

***Signature (Patient or Guardian)_____ Date_____**

We thank you for taking the time to complete this form and for choosing Optic Gallery for your vision care