WELCOME TO CENTURY EYECARE OPTOMETRY

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME	FIRST	MI	☐ MALE ☐ FEMALE	BIRTHDATE / /	AGE
ADDRESS	CITY	STATE	ZIP	GUARDIAN (IF APPLICABLE)	
HOME TEL ( ) WORK TEL ( ) CELL/ALT. TEL ( )	REFERRED BY: RELATIVE / FRIEND _____ ☐ INTERNET ☐ YELLOW PAGES ☐ INS. LIST ☐ WALK-IN ☐ OTHER				
EMPLOYER	OCCUPATION	SOCIAL SECURITY #		DRIVERS LICENCE #	EXP.
Email Address	Emergency Contact	Phone		Relationship	

INSURANCE

1. Do you have Medical Insurance? Y N Name of plan: _____ ID# _____
2. Who is your Primary Care Physican? Name: _____
3. Do you have Vision (Optical) Insurance? Y N Name: VSP Eyemed Other _____

Please give your insurance cards to receptionist so copies can be made.

I hereby authorize the physician to release any information required to process insurance claims. I also authorize my insurance benefits to be paid directly to the physician and I understand I am financially responsible for non-covered services.

Signature: _____ Date: _____

PATIENT HISTORY

1. You are here for: ☐ Eye exam for glasses
   ☐ Contact lens exam ☐ Eye disease ☐ Laser surgery consult
   ☐ Other _____
2. Have you had your eyes examined in this office before? Y N
3. Last eye exam _____ from Dr. _____
4. Do you currently wear: ☐ Eyeglasses? How old? _____
   ☐ Contact Lenses? How old? _____
5. Have you worn: ☐ Eyeglasses When? _____
   ☐ Contact lenses in the past?
6. If you now wear contact lenses, fitted by _____
   Brand _____
   ☐ Gas Perm. ☐ Astigmatism ☐ Soft ☐ Color
   How often do you replace them? _____
7. What sports, hobbies do you enjoy? _____
   _____
8. Are you taking any medications? Y N
   Please list _____
   _____
9. Are you allergic to any medications? Y N
   Please list _____
   _____
10. Have you ever had an eye injury, disease, or eye surgery? Y N
    Please list _____
11. Do any immediate blood relatives have:
    ☐ Diabetes ☐ Glaucoma
    ☐ Cataracts ☐ macular degeneration

Do you have or have you ever had problems in the following areas?

	YES	NO	If yes, explain.
Loss of vision	☐	☐	
Blurred vision	☐	☐	
Double vision	☐	☐	
Burning / watery eyes	☐	☐	
light sensitivity	☐	☐	
flashes / floaters in vision	☐	☐	
cataracts	☐	☐	
Glaucoma	☐	☐	
Macular / retinal problems	☐	☐	
Other eye problems:	☐	☐	
Headaches	☐	☐	
Seizures	☐	☐	
Arthritis	☐	☐	
Thyroid problems	☐	☐	
Kidney problems	☐	☐	
Psychiatric	☐	☐	
Allergies / Hay fever	☐	☐	
Sinus problems	☐	☐	
Asthma	☐	☐	
High Cholesterol	☐	☐	
Diabetes	☐	☐	
High blood pressure	☐	☐	