CORNEA & CONTACT LENS ASSOCIATES SIGN IN SHEET

PATIENT INFORMATION

EXAM DATE: / /

LAST NAME _____ FIRST NAME _____ [ ] MALE [ ] FEMALE DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PREFERRED TELEPONE NUMBER _____HOME/WORK/CELL (CIRCLE ONE) SECONDARY NUMBER _____ HOME/WORK/CELL (CIRCLE ONE)

EMPLOYER _____ OCCUPATION _____

REFERRED BY _____ EMAIL ADDRESS _____ SIGNATURE _____

INSURANCE INFORMATION

PLAN NAME _____GROUP _____

INSURED NAME _____ RELATIONSHIP TO PATIENT [ ] SELF [ ] SPOUSE [ ] CHILD (CHECK ONE PLEASE)

INSURED ID/MEMBER ID _____ INSURED DATE OF BIFTH _____ INSURED SSN _____

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM? _____

_____

ARE YOU PLANNING ON PURCHASING GLASSES OR CONTACTS TODAY? [ ] YES [ ] NO

WHAT IS THE AGE OF YOUR CURRENT GLASSES? _____ DATE OF LAST EYE EXAM? _____

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, ETC.) HAVE ANY OF THESE FOLLOWING CONDITIONS?

	SELF	RELATIVE	NONE
[ ] DIABETES	[ ]	[ ]	[ ]
[ ] HYPERTENSION	[ ]	[ ]	[ ]
[ ] THYROID	[ ]	[ ]	[ ]
[ ] HEART DISEASE	[ ]	[ ]	[ ]
[ ] ASTHMA	[ ]	[ ]	[ ]
[ ] CANCER	[ ]	[ ]	[ ]

	SELF	RELATIVE	NONE
[ ] GLAUCOMA	[ ]	[ ]	[ ]
[ ] CATARACTS	[ ]	[ ]	[ ]
[ ] RETINAL DISEASE	[ ]	[ ]	[ ]
[ ] EYE SURGERY	[ ]	[ ]	[ ]
[ ] EYE INJURY	[ ]	[ ]	[ ]
[ ] OTHER: _____	[ ]	[ ]	[ ]

	YES	NO
[ ] DO YOU SEE DOUBLE?	[ ]	[ ]
[ ] FREQUENT HEADACHES?	[ ]	[ ]
[ ] ARE YOU PREGNANT?	[ ]	[ ]
[ ] ARE YOU LIGHT SENSITIVE?	[ ]	[ ]
[ ] HAVE YOU BEEN DILATED?	[ ]	[ ]

PRIMARY CARE PHYSICIAN _____

PLEASE EXPLAIN ANY POSITIVE ANSWER'S _____

_____

_____

ARE YOU TAKING ANY SYSTEMIC MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER VARIETY)? PLEASE LIST:

_____

_____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN _____

_____

_____

_____

DO YOU USE ANY TYPE OF EYE DROP (PRESCRIPTION OR OVER THE COUNTER VARIETY)? PLEASE LIST:

_____

_____