

Patient Information Sheet

Date _____
Patient Name _____ Home phone _____
Social Security # _____ Male Female Cell phone _____
Address _____ Birthday _____
City _____ State _____ Zip _____ Email _____
(Check appropriate box) Minor Single Married
Employer _____ Work Phone _____ Vision Insurance _____
Insurance Holder/Parent/Guardian _____ Insured's SS # _____
Insured's Birthday _____ Whom may we thank for referring you? _____
Person to contact in case of emergency _____

Please circle the following information if it applies to you.

Ocular Information

Do you have any problems with your vision? **YES** **NO**
Explain, _____
Date of last Exam? _____
Who is your doctor? _____
Were your eyes dilated? **YES** **NO**
Dilation is highly recommended for patients over 40, or have a medical condition that can affect the health of the eye.
Would you like to be dilated today? **YES** **NO**
Do you wear glasses now? **YES** **NO**
Do you wear contacts? **YES** **NO**
If yes prescription renewal needed? **YES** **NO**
If no, are you interested in contacts? **YES** **NO**
Do you have any of the following eye conditions?
Glaucoma Amblyopia (lazy eye)
Cataracts Eye Surgery
Others: _____

Please Circle the following information if it applies to you.

Medical History

When was you last physical exam? _____
Who is your primary care doctor? _____
Are you taking any medications? **YES** **NO**
Yes, please list _____
Are you allergic to any medications? **YES** **NO**
If yes, list _____
Do you have, or have you had any of the following conditions?
Diabetes **YES** **NO** How Long? _____
High Blood pressure **YES** **NO** How Long? _____
Other medical conditions: _____
Family History
Do you have a family history of any of the following conditions?
Diabetes **YES** **NO** Who? _____
High Blood Pressure **YES** **NO** Who? _____
Glaucoma **YES** **NO** Who? _____
Others: _____

Authorize, Release, And Acknowledge

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly or to the doctor. Eye ware is custom ordered. There will be no refunds for services or products. Orders not picked up within 60 days will be returned and deposits will be lost. Diagnostic medical testing done in office, will be filed under your medical insurance. Amounts not paid by insurance are the patients responsibility. I also acknowledge that Eyedeals Optometry's Notice of Privacy Practice is available for me to read in the waiting room at any time and copies will be given upon request.

Signature of Patient (or parent/ guardian if minor) _____