WELCOME TO EYES ON HIGH

Reason for today's visit:____

How did you hear about us? ____

PERSONAL INFORMATION

Name Dr Mr Mrs Ms: ______________________________________Nickname: ________________

Date of Birth:________________________ Social Security #:________________________________

Address: ___________________________ City/State/Zip:___________________________________

Phone number (Home or Cell):_______________ email:____________________________________

Occupation: __________________________ Hobbies: _____________________________________

Parent/Legal Guardian:____

INSURANCE INFORMATION

Primary **VISION** Plan: ________________________ ID#___________________________________

Policy Holder Name:__________________ Policy Holder SS #(last 4) ______DOB:____________

Secondary **VISION** Plan Name: ____________________ ID#________________________________

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Primary **MEDICAL** Insurance:________________________ ID#_____________________________

Policy Holder Name:___________________ Policy Holder SS # __________DOB:____________

Secondary **MEDICAL** Insurance:________________________ ID# __________________________

*Any deductibles and/or copayments must be paid at the time of visit. We accept cash, check, Visa, Mastercard, Discover. Ask us about **Care Credit** today!

PERSONAL EYE HISTORY

CHECK ALL THAT APPLY:

Glasses:	**Contact Lenses:**	**Eye Conditions:**	
____I do not wear glasses	____I do not wear contacts	___ Injuries	____Amblyopia
____Distance/Driving only	____I would like to try contacts	___Glaucoma	___Eye Surgery
____Near/Reading only	____Daily Wear ____Overnight wear	___Cataracts	
____Full Time	Current brand:	___Macular degeneration	____ diabetic retinopathy
Age of current glasses:_______	I replace my contacts every:_______	___Retinal detachments	

Prior Eyecare provider:_________________ Last eye exam: ______________________________________

Prior Eye Surgeries:____________________ List of current eye medications:________________________

CHECK ALL THAT APPLY:

PERSONAL HEALTH HISTORY						
	YES	**NO**			**YES**	**NO**
Diabetes			type 1 or type 2	**Cancer**		
Hypertension				**Migraines**		
High Cholesterol				**Acid Reflux**		
Heart Disease				**Arthritis**		
Cancer				**Respiratory**		
Thyroid			high or low	**Allergies**		
Strokes				**Other:**		

Do you smoke? No / Former smoker / Yes, ___________ packs per day
Do you drink alcohol? No / Yes, ____________ drinks per week
List of current medications:____

____

Are you allergic to any medications? No / Yes:____

FAMILY HEALTH HISTORY				
	Father	Mother	Sister	Brother
Cancer				
Type 1 Diabetes				
Type 2 Diabetes				
High Blood Pressure				
Hypothyroid (low)				
Hyperthyroid (high)				

FAMILY OCULAR HISTORY					
	Grandparent	Father	Mother	Sister	Brother
Glaucoma					
Macular Degeneration					
Cataracts					