



Patient Intake Form

Last Name		First Name		Middle
Birth Date		Sex: M F	Email	
Street Address		City		State Zip
Phone		Second Phone		
Employer			Occupation	
Primary Insurance Company			Phone ()	
Policy Name / ID #			D.O.B. If Required	
Secondary Insurance Company Name			Phone ()	
Secondary Policy Name / ID #			D.O.B. If Required	
Emergency Contact			Home Phone ()	
Primary Care Physician:			Home Phone ()	
Do you wear sunglasses? Yes No		Do your eyestrain from computers? Yes No		Do you smoke? Yes No

Medical History: *Please check if you have been **diagnosed with or treated for** the following.*

Diagnosed	Yes✓	Diagnosed	Yes✓	
Arthritis		High Cholesterol		
Cancer		HIV		
Cataracts		Loss Of Balance/Falls		
Diabetes		Macular Degeneration		
Eye Surgeries		Pregnant or Nursing		
Flashing Lights		Pulmonary Disease		
Glaucoma		Retinal Detachment		
Headaches/Migraines		Thyroid Problems		
Heart Disease		Vertigo		
Hepatitis		Vision Loss or Change In Vision		
High Blood Pressure		Visual Spots		
Medication/Prescription Over the counter	Dosage MG	Frequency #Times/ Day	Reason/ Condition Treated	Prescribing Doctor

I understand that under The Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

Patient Signature: _____ Date: _____