Carbon Valley Eye Care

Welcome to our office!

Today's Date:_____

❒ New Patient

❒ Previous Patient ❒Mom/Dad/Guardian is filling out this form; Name:_____

Patient Name:_____DOB:_____ ❒ M ❒ F

Mailing Address:_____City, Zip:_____

Phone: (cell)_____(home)_____

(work)_____Email_____

We have an automated system to remind you of scheduled appointments. (choose **at least one** and as many as you want)

❒ Text me ❒ Email me
❒ Call cell phone ❒ Call home phone

**********INSURANCE ***Please fill this section out, thank you.******** ❒ I am paying privately

Vision Insurance:_____Name of Policyholder (me ❒):_____

Policyholder DOB:_____Policy Holder last 4 of SSN:_____

Medical Insurance:_____ID No._____Group No._____

**********PERSONAL EYE HISTORY**********

Date of last eye exam:_____By Whom:_____

Do you have prescription glasses? ❒ Yes ❒ No How old are your eyeglasses?_____

Do you wear contact lenses? ❒ Yes ❒ No ❒ I would like to My contacts are ❒ great ❒ OK ❒ could be better

Special visual demands (work or hobbies):_____

Check any that apply to your eyes:

❒ blurry vision	❒ double vision	❒ irritation	❒ glare/light sensitivity
❒ dryness	❒ tearing	❒ pain	❒ itching
❒ redness	❒ flashes	❒ eye surgery	❒ had LASIK/PRK
❒ eye injury	❒ retina detachment	❒ macular degeneration	❒ glaucoma
❒ eye turn / lazy eye	❒ cataracts	❒ cataract surgery	❒ other _____

**********PERSONAL MEDICAL HISTORY**********

Are you allergic to any medications? ❒ No ❒ Yes, these:_____

Medications you take: ❒ none ❒ these:_____

Are you pregnant or nursing? ❒ yes ❒ no How is your general health? ❒ good ❒ fair ❒ poor

Do you smoke? ❒ yes ❒ no Your Physician:_____

Check all medical conditions that apply to you:

❒ diabetes	❒ high blood pressure	❒ high cholesterol	❒ heart disease
❒ respiratory illness	❒ stroke/cerebrovascular	❒ skin problems	❒ psychiatric
❒ gastrointestinal	❒ arthritis	❒ cancer	❒ other _____

Please explain (as needed):_____

**********FAMILY HISTORY**********

Check if anyone related to you by blood has the listed condition:

❒ glaucoma	❒ macular degeneration	❒ blindness	❒ eye turn / lazy eye
❒ retina detachment	❒ diabetes	❒ heart disease	❒ other _____

Please explain (as needed):_____

~~PLEASE GIVE THIS COMPLETED PAGE TO THE FRONT DESK BEFORE CONTINUING WITH THE NEXT FORM~~