

Precision Eye Center – Patient Form

Patient Information

NAME _____ BIRTH DATE ____/____/____

SEX _____

SOCIAL SECURITY NUMBER _____

EMAIL _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____

HOME PHONE NUMBER _____

OCCUPATION _____

EMPLOYER _____

WORK PHONE NUMBER _____

CITY _____ STATE _____

ZIP _____

SPOUSE INFORMATION OR PARENT IF PATIENT IS UNDER 18 YEARS OF AGE

NAME _____

SPOUSE PARENT SOCIAL SECURITY NUMBER _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____

OCCUPATION _____

WORK PHONE NUMBER _____

VISION INSURANCE: BCBS VSP EYEMED MEDICARE MEDICAID CIMMARRON

OTHER _____

HEALTH INSURANCE: BCBS GREATWEST MEDICARE CIMARRON

OTHER _____

REFERRED BY _____

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. THERE WILL BE A \$30 SERVICE CHARGE ON ALL RETURNED CHECKS.

PERSON RESPONSIBLE FOR PAYMENT

1. Age of present glasses _____

Date of last eye exam _____ from Dr. _____

What sports or hobbies do you enjoy?

2. Do you or any family members have any of the following:

Diabetes yes / no who? _____

High blood pressure yes / no who? _____

Cataracts yes / no who? _____

Glaucoma yes / no who? _____

Retinal detachment yes / no who? _____

Retinal degeneration yes / no who? _____

Macular degeneration yes / no who? _____

Lung disease yes / no who? _____

Thyroid problems yes / no who? _____

Heart problems yes / no who? _____

Collagen vascular disease yes / no who? _____

Arthritis yes / no who? _____

Cancer yes / no who? _____

Other health concerns: _____

3. Are you currently taking any medication? Yes / No please list

4. Are you allergic to any medication? Yes / No please list

5. Do you smoke? Yes / No

6. Do you have any other allergies? (food, seasonal, etc) Yes / No please list

7. Have you ever had an eye infection, disease, injury, or surgery? Yes / No please list

8. Do your eyes burn, itch or tear unusually? Yes / No when

9. Have you ever seen flashes of light or floaters in you vision? Yes / No when

10. Do you ever see double? Yes / No when

11. Do you have frequent headaches? Yes / No when

12. Are you pregnant or nursing? Yes / No when _____
13. Do you have trouble with night vision? Yes / No conditions? _____
14. Have you ever worn contacts? Yes / No
If no, interested? Yes / No
15. Do you currently wear contacts? Yes / No
Type of contacts _____ solutions _____
16. Do you work on a computer? Yes / No hours per day _____
17. Do you plan on purchasing glasses or contact lenses today? Yes / No
18. Are you interested in LASIK or any other form of laser surgery? Yes / No