PARK MEADOWS VISION ASSOCIATES

DATE: ____/____/____

PATIENT INFORMATION: Circle: Male / Female Marital Status: Married / Single / Widowed

Last Name: _____ First Name: _____ M.I.: _____ Birthdate: _____ Age _____

Social Security #: _____ Last Eye Exam: _____ Previous Eye Dr.: _____

Home phone: ( ) _____ Daytime Phone: ( ) _____ Cell Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Work Phone: ( ) _____

Email Address: _____

How did you hear about our office? Prior Patient Drive-By Friend/Family Patient Insurance Internet Advertising

PARTY RESPONSIBLE FOR PAYMENT: Self Spouse Parent/Guardian Name: _____

SAME AS ABOVE _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: ( ) _____ Daytime Phone: ( ) _____ Cell Phone: ( ) _____

REASON FOR YOUR VISIT TODAY:

_____ Blurred Distance Vision _____ Blurred Near Vision _____ Seeing spots, floaters _____ Seeing flashes of light

_____ Eyes Itch, water or burn _____ Eye pain/discomfort _____ Frequent Headaches _____ Eye infection or discharge

Other reason for visit _____

VISUAL HISTORY: Do you wear glasses? Yes / No Near Only / Distance Only / Constant RX Sunglasses? Yes / No

Do you wear contacts? Yes / No If yes, type / power? _____

Interested in LASIK? Yes / No

OCULAR / MEDICAL HISTORY: Please check positive condition below and/or indicate close family members with condition.

Condition:	Self	Family Members (List Relation)
Amblyopia/Lazy Eye:		
Strabismus/Turned Eye:		
Dry Eye Syndrome/Symptoms:		
LASIK / RK Surgery:		
Cataracts or Cataract Surgery:		
Eye Surgery or Therapy:		
Eye Injury:		
Macular Degeneration:		
Glaucoma:		
Retinal Detachment/Hole/Repair:		
Hypertension:		
Elevated Cholesterol:		
Diabetes:		
Cancer (List Type):		
Thyroid Dysfunction (List Type):		
Gastrointestinal Dysfunction (List Type):		
Skin or Musculoskeletal Disorder (List Type):		
Nervous System Disorder (List Type):		
Arthritis (List Osteo or Rheumatoid Type):		

MEDICATIONS/DOSAGES:

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: _____

_____

_____

_____

SOCIAL HISTORY:

Do you smoke? No / Yes packs/day

Do you consume alcohol? No / Yes

If yes, number of drinks/day

Do you use street drugs? No / Yes

If yes, what kind?

VISION INSURANCE: _____ Relationship of Patient to Primary: self spouse child

Primary Insured's Name: _____ Primary's Social Security #: _____

Primary's Birthdate: ____/____/____ Primary's Member #: _____ Group #: _____

Home Address/City/State/Zip: _____

Primary's Home phone: ( ) _____ Primary's Cell Phone: ( ) _____ Primary's Gender: M / F

Primary's Employer: _____ Co-Pay: _____

MEDICAL INSURANCE: _____ Relationship of Patient to Primary: self spouse child

Primary Insured's Name: _____ Primary's Social Security #: _____

Primary's Birthdate: ____/____/____ Primary's Member #: _____ Group #: _____

Home Address/City/State/Zip: _____

Primary's Home phone: ( ) _____ Primary's Cell Phone: ( ) _____ Primary's Gender: M / F

Primary's Employer: _____ Co-Pay: _____

OFFICE USE BELOW THIS LINE: Exam type: GXM CLXMPW CLXMNW CLXM CLFIT ONLY OV **NEW** **EXISTING**

Dr: _____ **Appt. Time:** _____ **Copays:** XM: _____ FIT: _____ / Specialty Fit CL's: _____ OV: _____ OPTOS: Y / N / + / ?'s