

WELCOME BACK
Please update the following information for our files

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Insurance: _____ Primary subscriber _____ DOB _____
ID# or SS# of primary insurance subscriber _____

VISUAL AND MEDICAL HISTORY

Date of last eye exam _____

Briefly describe your reason for today's visit: _____

Do you wear contact lenses? If yes what type: _____

Please place a check next to all that applies to yourself or any blood relatives:

| | Self | Family | | Self | Family |
|-----------------------|------|--------|-------------------------|------|--------|
| Diabetes: | ___ | ___ | Glaucoma: | ___ | ___ |
| High Blood Pressure: | ___ | ___ | Retinal Detachment: | ___ | ___ |
| Heart problems: | ___ | ___ | Lazy Eye: | ___ | ___ |
| Arthritis: | ___ | ___ | Macular Degeneration: | ___ | ___ |
| Cancer: | ___ | ___ | High cholesterol | ___ | ___ |
| Thyroid: | ___ | ___ | Other: | ___ | ___ |
| Respiratory problems: | ___ | ___ | (please describe) _____ | | |

Have you experienced any of the following? Please check all that apply

| | | | | | |
|------------------|-----|--------------------------------|-----|---------------------|-----|
| Double vision | ___ | Headaches (on a regular basis) | ___ | Eye Injury | ___ |
| Flashes of light | ___ | Sudden loss of vision | ___ | Halos around lights | ___ |
| Floaters (spots) | ___ | Head Injury | ___ | | |
| Dry eyes | ___ | Excessive tearing | ___ | | |

Please list all medications that you take on a regular basis (including birth control and over the counter medications) _____

Please list any allergies you may have (including environmental) _____

Have you ever had your eyes dilated? _____ When? _____

I authorize the release of any Medical or other information necessary to process any insurance claims. I also authorize payment of benefits to Long Island Optometric Eyecare, PC. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date _____ 20__