WELCOME TO LI OPTOMETRIC EYECARE

Name: ______________________________ DOB: ______________

Address: ____________________ City: ______________ Zip: ________

Home Phone: ______________ Work or Cell Phone: ____________________

Email: ______________________ Occupation: ____________________

Insurance Name: __________ Primary Subscriber ______________ DOB __________
ID# or SS# of primary subscriber ______________________________

How did you hear of us? Web site_____ Insurance Plan_____ Friend/Family_____ Yellow Book_____
Previous Patient______ Other ____ (explain) ______

VISUAL AND MEDICAL HISTORY

Date of last eye exam: ______________ By whom: ______________
Briefly describe your reason for today's visit: ______________________________

____

Do you wear contact lenses? If yes what type:___ disposable ____astigmatic____bifocal____yearly____Gas perm
Please place a check next to all that applies to yourself or any blood relatives:

	Self	Family
Diabetes:	___	___
High Blood Pressure:	___	___
Heart problems:	___	___
Arthritis:	___	___
Cancer:	___	___
Thyroid:	___	___
Respiratory problems:	___	___

	Self	Family
Glaucoma:	___	___
Retinal Detachment:	___	___
Lazy Eye:	___	___
Macular Degeneration:	___	___
High Cholesterol:	___	___
Other:	___	___

(please describe) ____________________

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

Double vision ___
Flashes of light ___
Floaters (spots) ___
Dry eyes ___

Headaches (on a regular basis) ___
Sudden loss of vision ___
Head Injury ___
Excessive tearing ___

Eye Injury ___

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___