WELCOME TO LI OPTOMETRIC EYECARE

Name: _____DOB:_____

Address: _____City:_____Zip:_____

Home Phone: _____Cell Phone: _____

Email: _____Occupation:_____

Insurance: Vision_____Medical_____
Primary holder of insurance name :_____DOB_____

ID# or SS# of primary insurance holder_____

How did you hear of us? Website___Insurance plan___Family/friend___who?_____ other_____
Preferred method of contact (please circle): email, text, cell phone, home phone

Date of last eye exam_____ Date of last Physical _____
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:	___	___	Respiratory(Asthma, COPD)	___	___
High Blood Pressure:	___	___	EYE CONDITIONS:		
High cholesterol	___	___	Glaucoma:	___	___
Heart problems:	___	___	Retinal Detachment:	___	___
Rheumatoid Arthritis:	___	___	Lazy Eye (amblyopia):	___	___
Cancer(Type):	___	___	Macular Degeneration:	___	___
Thyroid condition	___	___	Cataracts:	___	___

Other:(describe) _____

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

Double vision	___	Headaches (regularly)	___	Eye Injury(when)	___
Flashes of light	___	Sudden loss of vision	___	Halos around lights	___
Spots/floaters	___	Head Injury	___	Blurred vision	___
Dryness	___	Excessive tearing	___	Eye Irritation	___

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: contact lens solutions, silicone, medications and environmental)
_____
_____

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___