**WELCOME BACK**

**Please update the following information for our files**

Name: ______________________________________________DOB:________________________

Address: ________________________________City:_______________________Zip:_________

Home Phone: ___________________________Cell Phone: _____________________________

Email: _____________________________________Occupation:___________________________

Insurance: Vision________________________________Medical__________________________

Primary holder of insurance______________________________________DOB______________

ID# or SS# of primary insurance holder_______________________________

Preferred method of contact (please circle): email, text, cell phone, home phone

## VISUAL AND MEDICAL HISTORY

Date of last eye exam___________________ Date of last Physical______________________

Briefly describe any issues or concerns you may be having:___________________________________

_____________________________________________________________________________

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: | ___ | ___ | Glaucoma: | ___ | ___ |
| Heart problems: | ___ | ___ | Retinal Detachment: | ___ | ___ |
| Arthritis: | ___ | ___ | Lazy Eye (amblyopia) | ___ | ___ |
| Cancer (if yes: type?) | ___ | ___ | Macular Degeneration: | ___ | ___ |
| Thyroid: | ___ | ___ | Cataracts | ___ | ___ |
| High cholesterol | ___ | ___ | Other(describe)_____________________ | | |

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

| | | | | | |
|---|---|---|---|---|---|
| Double vision | ___ | Headaches (regularly) | ___ | Eye Injury(if yes,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 environmental,medications,silicone,contact lens solutions)

_____________________________________________________________________________

_____________________________________________________________________________

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___