PATIENT INFORMATION FORM

Please take a minute to complete this information form. This will help us to maintain more accurate records in our office.

Name _____
First Middle Initial Last

Address _____
Street or P.O. Box City State Zip Code

Work# _____ Cell# _____ Home# _____

Age _____ Date of Birth _____ ☐Male ☐Female

Who recommended you to our office? _____

Family Doctor _____

Social Security # _____

If minor, please give parent or guardian's name: _____

Employer _____

If married, spouse's name _____ Employer _____

Spouses Date Of Birth _____ Spouse's S.S.# _____

Past history: Please check one.	Yes	No
High Blood Pressure	☐	☐
Heart Problems	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Cross-Eyed	☐	☐

Please List Medications: _____

_____

_____

Are you allergic to any medications? _____

Do you, or have you ever worn glasses? ☐ Yes ☐ No - If so, how many years? ___

Have you ever had any kind of surgery? ☐ Yes ☐ No - Please list below:

_____

_____

_____