(must be updated at every visit)

PATIENT INFORMATION: NEW PATIENT EST. PATIENT **TODAY'S DATE: _____**

Last Name_____First Name_____ Male Female

Address_____City_____State_____Zip_____

Birth date_____Age_____Home/Cell Phone _____Email_____

REASON FOR TODAY'S VISIT

☐ Routine Eye Exam/Glasses Exam
☐ Contact Lens Exam and Lenses
☐ Refractive Surgery (LASIK) Evaluation
☐ Retinal photo (for monitoring patients with high blood pressure, diabetes, glaucoma, macular degeneration, etc.)

Date of Last Eye Exam_____

☐ Other_____

Previous Eye Dr. _____ PCP _____

MEDICAL AND EYE HISTORY

Do you have: (please circle)

High blood pressure…..No…..Yes
Diabetes……..No…..Yes
Heart Disease……No…..Yes
High Cholesterol……..…No…..Yes
Cancer……No…..Yes
Glaucoma……...No…..Yes
Cataracts……No…..Yes
Inherited Diseases…….No…..Yes
Allergies……...No…..Yes
Thyroid……..……...No…..Yes

Does anyone in your family have:

High blood pressure…….No…..Yes, who?_____
Diabetes……No…..Yes, who?_____
Heart Disease……...No…..Yes, who?_____
High Cholesterol……...No…..Yes, who?_____
Cancer……...No…..Yes, who?_____
Glaucoma……...No…..Yes, who?_____
Macular Degeneration ……No…..Yes, who?_____
Inherited Diseases……...No…..Yes, who?_____

Any other Health Problems_____ Any other Eye Problems/Surgeries_____
Are you pregnant?…… No…..Yes
Did you have **LASIK?**..No…..Yes If yes, when?_____
List any **medications** you are taking _____
Allergies to any medications?…..No…..Yes _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substances? _____
Does your occupation or your hobbies require an impact-resistant lens or safety frame/lenses? ……..No…..Yes

CONTACT LENS INFORMATION

Do you wear contact lenses? ……. No…..Yes
If yes:…..Soft Disposable…..Conventional Hard/Gas Permeable…..Scleral
How often do you change your lenses?_____
Do you sleep in your contacts?…..No…..Yes If yes, how many days maximum?_____

VISION INSURANCE – *IF APPLICABLE*

Name of Vision Insurance? …..VSP(Vision Service Plan)…..Eyemed…..Avesis
Your Social Security #_____
Primary Member's Name_____Primary Member's Birthdate _____
Relation to Member? …..Self…..Spouse…..Dependent
Primary Member's Social Security #_____

I hereby authorize payment of my insurance benefits to Daynes EyeCare. I understand I am financially responsible for any charges, whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Daynes EyeCare. I authorize Daynes EyeCare to release any information required to process any and all claims for reimbursement on my behalf.

Signature_____Date_____