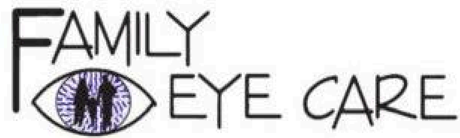

Name: ____ **Preferred Name:** ____________________________

Birth Sex: ☐ Male ☐ Female **DOB** _____/______/________ **Social Security #** _________-________-_________

Street ____ **City**_______________________ **State**________ **Zip**__________
Phone Numbers: **Home** ______________________ **Cell** ______________________ **Work** ______________________
Email Address: ____

Ethnicity	**Preferred Language**	**Race**	
◻ Decline to specify	◻ Decline to specify	◻ Decline to specify	◻ Hispanic
◻ Hispanic/Latino	◻ English	◻ Alaska Native	◻ Native Hawaiian or
◻ Not Hispanic/Latino	◻ Spanish	◻ Asian	Other Pacific Islander
	◻ Other ___________	◻ Black/African-American	◻ White

Marital Status: ◻Single ◻Married ◻Divorced ◻Separated ◻Widowed

Employment Status: ◻Employed Full-Time ◻Employed Part-Time ◻Retired ◻Full-Time Student

How did you hear about our office? ◻Internet ◻ Doctor: ______________________ ◻Patient Referral: ______________________

PHARMACY
Name ____
Phone ___________________ Fax ___________________
Address ____
City_________________________State______Zip_______

PRIMARY CARE PHYSICIAN
Date of last physical exam: ______/______/________
with Dr . ______________________________________
Phone ___________________ Fax ___________________
Address____
City_________________________State______Zip________

Emergency Contact Name _________________________ Relationship ____________ Phone _________________________

***** Please disregard this section if we have scanned your insurance cards! *****

RESPONSIBLE PARTY

Name ____ **Relationship to Patient** ______________________
Responsible Party's DOB _____/____ /_______ **SS #** ________-________-________
Primary Medical Insurance ____________________________________ ID# ____
Policyholder's Name ____ DOB _____/____/_______
Secondary Medical Insurance __________________________________ ID# ____
Policyholder's Name ____ DOB _____/____/_______
Vision Plan/Union ____ ID# ____
Member's Name ____ DOB _____/____/_______

MEDICAL HISTORY

Medications *Please list all medications you are currently taking below, and for what conditions.*

____
____
____

Allergies *Please list any allergies below.*

____

Surgeries *Please list any surgeries below, as well as the date it was performed.*

____

OCULAR HISTORY

Do you wear glasses? ☐ None ☐ Distance ☐ Reading ☐ Bifocal ☐ Progressive ☐ Rx Sunglasses

Do you wear contact lenses? ☐ Yes ☐ No **If not, are you interested in contact lenses?** ☐ Yes ☐ No

Have you ever injured your eyes? How? ______________________________ When? ________________________

Do you use eye drops? Explain (Name, How often, etc.) ____

SOCIAL HISTORY

Do you drink alcohol? ☐No ☐Yes, How Often ____________

Do you smoke? ☐No ☐Yes, How Often ____________ If quit, how long ago? _______________________

I certify that information pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Family Eye Care of Medford. I authorize release of medical information necessary to process this (these) claim(s). I have read all terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature: ____ Date: _______________________