# Carbon Valley Eye Care

**Welcome to our office!** Today's Date:_____

❒ New Patient ❒ Previous Patient

❒ Mom/Dad/Guardian is filling out this form. Name:_____

## DEMOGRAPHICS

Patient Name:_____ Preferred Name:_____

DOB:_____ ❒ M ❒ F ❒ U Occupation:_____

Mailing Address:_____ City, Zip:_____

Phone: (cell)_____ (home)_____

Email_____

How would you like to be contacted about upcoming appointments?

❒ Text me ❒ Email me ❒ Call cell ❒ Call home

## INSURANCE/PAYMENT

**Please fill this section out correctly, failure to do so will result in you being billed directly**

☐ **VISION PLAN – for well vision ("routine") exams**

Plan name:_____ Name of Policyholder (me ❒):_____

Policyholder DOB:_____ Policy Holder last 4 of SSN:_____

Policyholder ID # (if applicable):_____

Policyholder address: (same as above❒):_____

☐ **MEDICAL INSURANCE**

Insurance name:_____ Name of policyholder (me ❒):_____

ID No._____ Group No._____

Policyholder address (same as above❒):_____

☐ **I am paying privately**

## EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone:_____

PLEASE FILL OUT BACK SIDE OF ALL PAGES NECESSARY

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## PERSONAL EYE HISTORY

Date of last eye exam:_____ By Whom:_____

Do you have prescription glasses? ❒ Yes ❒ No How old are your eyeglasses?_____
Do you wear contact lenses? ❒ Yes ❒ No ❒ I would like to My contacts are ❒ great ❒ OK ❒ could be better

Special visual demands (work or hobbies):_____

Check any that **currently** apply to your eyes:

| | | | |
|---|---|---|---|
| ❒ blurry vision | ❒ itching | ❒ cataracts | ❒ eye surgery |
| ❒ dry eye | ❒ pain | ❒ cataract surgery | ❒ LASIK/PRK |
| ❒ redness | ❒ double vision | ❒ macular degeneration | ❒ eye turn/lazy eye |
| ❒ tearing | ❒ flashes | ❒ glaucoma | ❒ eye injury |
| ❒ irritation | ❒ glare/light sensitivity | ❒ retinal detachment | ❒ other: _____ |

Please explain (as needed):_____

## PERSONAL MEDICAL HISTORY

Are you allergic to any medications? ❒ No ❒ Yes, these:_____

Medications you take: ❒ none ❒ these:_____

Are you pregnant or nursing? ❒ yes ❒ no Do you smoke? ❒ yes ❒ no

Your Physician:_____ Practicing at:_____

Specialists (as needed- endocrinologist, rheumatologist):_____

Check all medical conditions that apply to you:

| | | | |
|---|---|---|---|
| ❒ diabetes | ❒ high blood pressure | ❒ high cholesterol | ❒ cardiovascular |
| ❒ respiratory illness | ❒ cerebrovascular | ❒ skin problems | ❒ psychiatric |
| ❒ gastrointestinal | ❒ arthritis | ❒ cancer | ❒ other: _____ |

Please explain (as needed):_____

## FAMILY EYE AND MEDICAL HISTORY

Check if anyone related to you by blood has the listed condition:

| | | | |
|---|---|---|---|
| ❒ glaucoma | ❒ blindness | ❒ retinal detachment | ❒ diabetes |
| ❒ macular degeneration | ❒ eye turn/lazy eye | ❒ other: _____ | ❒ cardiovascular |

Please explain (as needed):_____

PLEASE FILL OUT BACK SIDE OF ALL PAGES NECESSARY