Carbon Valley Eye Care

Welcome to our office!

Today's Date:________________

❒ New Patient
❒ Previous Patient ❒Mom/Dad/Guardian is filling out this form; Name:____________________________

Patient Name:____________________________________DOB:__________________________ ❒ M ❒ F

Mailing Address:____City, Zip:____________________________

Phone: (cell)______________________________________(home)____________________________________

(work)____Email______________________________________

We have an automated system to remind you of scheduled appointments. (choose **at least one** and as many as you want)

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

******************INSURANCE ***Please fill this section out, thank you.******** ❒ I am paying privately

Vision Insurance:___________________________Name of Policyholder (me ❒):________________________
Policyholder DOB:___________________________Policy Holder last 4 of SSN:_________________________

Medical Insurance:__________________ID No._____________________________Group No.____________

***********************************PERSONAL EYE HISTORY************************************

Date of last eye exam:_________________________By Whom:____
Do you have prescription glasses? ❒ Yes ❒ No How old are they?_______________________
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 apply to your eyes:

❒ blurry vision	❒ double vision	❒ irritation	❒ glare/light sensitivity
❒ dryness	❒ tearing	❒ pain	❒ itching
❒ redness	❒ flashes	❒ eye surgery	❒ had LASIK/PRK
❒ eye injury	❒ retina detachment	❒ macular degeneration	❒ glaucoma
❒ eye turn / lazy eye	❒ cataracts	❒ cataract surgery	❒ other ______________

*********************************PERSONAL MEDICAL HISTORY*********************************

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

Medications you take: ❒ none ❒ these:____

____

Are you pregnant or nursing? ❒ yes ❒ no How is your general health? ❒ good ❒ fair ❒ poor
Do you smoke? ❒ yes ❒ no Your Physician:_______________________________
Check all medical conditions that apply to you:

❒ diabetes	❒ high blood pressure	❒ heart disease	❒ cancer
❒ respiratory illness	❒ stroke/cerebrovascular	❒ skin problems	❒ psychiatric
❒ gastrointestinal	❒ arthritis	❒ autoimmune	❒ other ______________

Please explain (as needed):____

____

***************************************FAMILY HISTORY**************************************

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

❒ glaucoma	❒ macular degeneration	❒ blindness	❒ eye turn / lazy eye
❒ retina detachment	❒ diabetes	❒ heart disease	❒ other ______________

Please explain (as needed):____

____

PLEASE GIVE THIS COMPLETED PAGE TO THE FRONT DESK BEFORE CONTINUING WITH THE NEXT FORM