PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Vision Insurance Company _____

Insurance ID# (or social security #) _____

Family members who are patients of Metropolitan Eyecare (any location) _____

_____

How were you referred to our office? _____

RESPONSIBLE PARTY INFORMATION (if other than above):

Insured/Responsible Party Name _____ Date of Birth _____

Relationship _____ SS# _____ Phone # _____

Address _____ City _____ State _____ Zip _____

HISTORY

Do you wear glasses now? _____ For approximately how many years? _____ Do you wear reading glasses? _____

Do you have bifocals? ____ With a line? ____ Without a line? ___ Do you use a computer more than 30 minutes a day? _____

Have you ever worn contact lenses? _____ How long ago? _____ Brand _____

What type? Hard_____ Gas permeable_____ Soft_____ Toric _____ Are you interested in trying contact lenses? _____

Please check any of the following that apply to you or family members:

	Self	Family Members		Self	Family Members
Cataracts	_____	_____	High Blood Pressure	_____	_____
Glaucoma	_____	_____	Heart Disease	_____	_____
Crossed Eye	_____	_____	Asthma	_____	_____
Macular degeneration	_____	_____	Sinus trouble	_____	_____
Blindness	_____	_____	Poor night vision or glare	_____	_____
Eye infections	_____	_____	Eyes burn, itch or tear	_____	_____
Eye injury	_____	_____	See spots or flashes	_____	_____
Seasonal allergies	_____	_____	Dry eyes	_____	_____
Diabetes	_____	_____	Double vision	_____	_____
Eye surgery	_____	_____	Headaches or eye pain	_____	_____
Eye diseases	_____	_____	Head injury	_____	_____

Other conditions not listed above _____

Approximate date of last eye exam: _____ Doctor: _____

Please list any prescription drugs you are taking (including birth control pills): _____

_____

_____

List any drug you are allergic to: _____ Latex? _____

INTERESTS:

Hobbies _____ Sports _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND METROPOLITAN EYECARE PAYMENT POLICY

I understand I am responsible for any insurance copays or other outstanding balances at time of visit.
I hereby acknowledge that I have been given a copy of Metropolitan Eyecare's Notice of Privacy Practices.

Patient Name (please print): _____

Signature _____ Date: _____

Patient or parent/guardian (if patient is a minor)

Relationship to patient (if not patient) _____