

PATIENT INFORMATION FORM

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

INSURANCE TYPE: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS:

DO YOU WEAR CONTACT LENSES? Y N GLASSES? Y N

ARE YOU INTERESTED IN CONTACT LENSES? Y N

ARE YOU INTERESTED IN NEW GLASSES? Y N

REASON FOR TODAY'S VISIT: \_\_\_\_\_

DATE OF LAST MEDICAL EXAM: \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ PHONE #: \_\_\_\_\_

LIST ALL MEDICATIONS THAT YOU TAKE: \_\_\_\_\_

PLEASE LIST ANY ALLERGIES TO MEDICATIONS: \_\_\_\_\_

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING: (PLEASE CHECK)

\_\_\_ FLOATERS/SPOTS \_\_\_ FLASHES \_\_\_ DOUBLE VISION \_\_\_ EYE INJURY \_\_\_ HEAD INJURY

PLEASE LIST ANY EYE SURGERIES WITH DATES: \_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING: (PLEASE CHECK)

\_\_\_ DIABETES \_\_\_ THYROID DISEASE \_\_\_ HYPERTENSION \_\_\_ OTHER \_\_\_\_\_

FEMALES: ARE YOU PREGNANT? Y N IF SO, HOW MANY MONTHS? \_\_\_\_\_

DO YOU USE ANY RECREATIONAL DRUGS? Y N DO YOU SMOKE? Y N

DOES ANYONE/HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD: (PLEASE CHECK)

\_\_\_ CATARACTS \_\_\_ GLAUCOMA \_\_\_ RETINAL DETACHMENT \_\_\_ MACULAR DEGENERATION

\_\_\_ LAZY EYE \_\_\_ OTHER \_\_\_\_\_

I GIVE FAMILY EYE CARE SERVICES/DR. KAPLAN PERMISSION TO BILL MY INSURANCE LISTED ABOVE. I AM AWARE THAT I AM FINANCIALLY RESPONSIBLE, IN FULL FOR ALL SERVICES RENDERED ON THIS DATE AND ANY OTHER DATES OF SERVICE THAT ARE NOT COVERED BY MY INSURANCE PLAN.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_