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EYECONIC EYE CARE OPTOMETRY

PATIENT INTAKE FORM

Name: Last: ______________________ First: ______________________ MI: ________

Date of Birth: ______________________ Social Security #: ______________________ Gender: M / F

Home Address: ______________________ City: ______________ State: __________ Zip: ________

Email Address: ______________________ Phone #: ______________ Cell Phone #: ______________

Occupation: ______________________ School Name: ______________________

Parent/Guardian: ______________________ Relationship to patient: ______________

Emergency Contact Name: ______________ Relationship: ______________ Phone#: ______________

How did you hear about us? ______________________

Vision Insurance: ______________ Member ID# ______________ Relation to Primary: ________

Policy Holder: ______________ SSN#: ______________ Primary's DOB: ________

Medical Insurance: ______________ Member ID# ______________ Relation to Primary: ________

Policy Holder: ______________ SSN#: ______________ Primary's DOB: ________

Payment Policy: I agree to assume all financial responsibilities incurred for care. I authorize my insurance carrier(s) to pay directly to Eyeconic Eye Care Optometry/Lau and Nguyen, Inc. benefits that are due to me under the terms of my policy. If the above insurance information is not correct, I agree pay in full for all services at the time they were provided. I authorized Eyeconic Eye Care Optometry/Lau and Nguyen, Inc. to release information to insurance carriers concerning my illness and treatment. The patient or responsible party will assume all costs incurred in collection of a delinquent account, either by collection of a delinquent account, collection agency, lawyer, or judicial systems.

Signature: ______________________ Date: ______________

OCULAR and MEDICAL HISTORY

Date of last eye exam: ______________ Primary care doctor: ______________

Do you wear glasses or contacts? Y / N ______________ Medical Allergy: ______________

Do you smoke or drink? How often? ______________ Medications you are taking: ______________

____

____

Check all that applies to you:

___Eye injury
___Eye surgery
___Glaucoma
___Cataract
___Macular degeneration
___Lazy Eye
___Blindness
___Itchy eyes
___Dry eyes
___Watery eyes
___Flashes
___Floaters
___Discharge
Other______________

Check all that applies to your Health:

___Cardiovascular
___High Blood Pressure
___Heart Disease
___Stroke
___Vascular disease
___ Endocrine
___Diabetes type 1 or 2
___Thyroid dysfunction
___Hormonal dysfunction
___Neurological
___Multiple Sclerosis
___ Epilepsy
___Migraine
___Cancer
___Psychiatric
___Depression

___Ears/nose/throat
___Sinusitis
___Dry Mouth
___Hearing Loss
___Allergic/Immunologic
___Rheumatoid Arthritis
___Lupus
___Respiratory Disorder
___Emphysema
___Bronchitis
___Asthma
___COPD
___Gastrointestinal
___Colitis
___Ulcer
___Crohn's

___Genitourinary
___Kidney Disease
___Prostate Disease/cancer
___Hematologic/Lymphatic
___Cholesterol
___Anemia
___Integumentary
___Rosacea
___Psoriasis
___Eczema
___Musculoskeletal
___Osteoarthritis
___Fibromyalgia
___Ankylosing Spondylitis
___Muscular dystrophy
Other______________

Check all that applies to your family members: **Please Specify Relationship**

__________Glaucoma
__________Cataract
__________Macular Degeneration

__________Lazy Eye
__________Retinitis Pigmentosa
__________Blindness

__________Diabetes
__________Heart Disease
__________High Blood Pressure

__________Cancer
__________Thyroid
Other______________