

Welcome to Town Center Eye Care

Patient Information

Name _____ Date _____ SS #: _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Birth date _____ E-Mail _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____
Do you prefer calls at: Home Work Cell No Preference
Marital Status: Married Widowed Single Minor Separated Divorced Partnered for __ yrs.
Patient Employer/School _____ Occupation _____
Spouse/or Minor Parent's Name _____
Whom may we thank for referring you to us? _____
Person to contact in emergency _____ Phone _____

Insurance

Vision Insurance Provider*: _____ ID # _____ Group# _____
Medical Insurance Provider*: _____ ID # _____ Group# _____

**Please bring your insurance card(s) to your appointment if one has been supplied to you by your insurance provider.*

History

Reason for today's exam _____ Age _____
Date of last exam _____ Name of Eye Doctor _____

Do you or anyone in your immediate family have a history of the following? Y or N

- Diabetes Cataracts Glaucoma Blindness
 Thyroid Heart Condition High BP Turned or lazy eye High Cholesterol

Please check any of the following that apply to you:

- Frequent Headaches Allergies Drug Allergies Sinus Trouble
 Pregnant Have given birth in the last six months

Please list all medications you are currently taking: _____

Have you ever had any of the following conditions involving your eyes?

- Eye Surgery Sensitivity to light Eye infection or disease
 Eye injury Floaters or Spots Double Vision
 Medical treatment Poor distance vision Eye Strain
 Severe pain Poor near Vision Eyes burn, itch or water

Do you currently wear glasses? Yes No

If yes, when do you wear your glasses?

- All the time Computer work Reading/ near work Distance Driving Other

Have you ever worn contact lenses? Yes No If yes, what type? Soft RGP/ Hard

Are you interested in wearing contact lenses? Yes No

Do you know what brand of lenses you are currently wearing? _____

Do your work at a computer or video display terminal? Yes No If yes, how many hours per day? _____

What hobbies or sports do you participate in? _____