Thank you for choosing Eyes of The World. We look forward to serving you.

First Name:_____

Middle:_____Last:_____

Date of Birth: _____DL Number: _____

Occupation:_____

Employer: _____

Spouse's/Parent's Name:_____

Spouse's/Parent's Workplace: _____

Address: _____House/Apt#:_____

City: _____State:_____Zip:_____

Home Phone: _____Cell Phone: _____

Other / Work Phone: _____

Email: _____

Are you: Minor Single Married Other

Whom may we thank for referring you? _____

There are two types of insurances that cover your eyes. Routine Vision Insurance covers your annual examination.

Your Medical Insurance covers any other office visits, i.e. injury or infections.

Reason for today's exam: _____

Date of last Exam:_____ Previous Doctor:_____

Vision Insurance: _____

Relationship to Primary Member: _____

Patient's S.S. #:_____Primary Member S.S. #:_____

Primary Member Date of Birth (If other than self): _____

Medical Insurance Provider: _____

I.D. #:_____

MEDICAL HISTORY:

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

Diabetes Cancer Blindness HBP Thyroid Glaucoma

Turned/Lazy Eye Cataracts Macular Degeneration

Do **you** have any of the following conditions?

Allergies Any Eye Surgery Dry Eye Headaches

Eye Infections/Problems Pregnant/given birth last 6 months

Please explain any circled conditions and who has them: _____

Are you currently being treated for anything medically: _____

Please list any medication you are taking: _____

Please list and medication you are allergic to: _____