PERSPECTIVE
FAMILY EYE CARE

Patient Information

Last Name_____ First Name_____ Date of Birth_____

Address_____

State_____ Zip code _____ Primary Phone _____

Email_____

Insurance Information

Vision/Insurance Plan_____ ID#_____

Relationship to Insured: Self / Spouse / Dependent (circle one)

Insured Name_____ Insured DOB_____

Medical History

Reason for Visit_____ Date of last Eye Exam_____

Age of present glasses_____
Current contact lens brand (if applicable)_____

Have you been diagnosed with the following?

□ Diabetes	□ Glaucoma
□ High blood Pressure	□ Cataracts
□ Thyroid problems	□ Retinal Disease
□ Heart Disease	□ Eye Surgery
□ Asthma	□ Eye Injury
□ Cancer	□ Double Vision
□ Frequent Headaches	□ Blindness

Has anyone in your family (grandparents, parents, siblings) been diagnosed with the following?

□ Diabetes	□ Glaucoma
□ High Blood Pressure	□ Cataracts
□ Thyroid problems	□ Retinal Disease
□ Heart Disease	□ Blindness
□ Cancer	

List any medications prescribed to you:_____

_____

Are you pregnant or nursing? Y or N
Do you have any allergies?_____

Signature X_____ **Date** _____