

PersonalEyes Vision Care

Patient Intake Form

Please complete all sections. Fields marked with * are required.

PATIENT INFORMATION

Title: _____ First Name*: _____ Last Name*: _____

Middle Initial: _____ Nickname: _____ Pronoun: _____ Occupation: _____

Address Line 1*: _____

Address Line 2 (Apt, Ste): _____

City*: _____ State*: _____ Zip Code*: _____

Home Phone: _____ Cell Phone*: _____ Email*: _____

Preferred Contact*: _____ Last 4 SSN: _____ Birthday* (MM/DD/YYYY): _____

Employer/School: _____ Misc/Guardian: _____

Marital Status: _____ Birth Sex*: Male Female

Authorized Persons to Release Medical Information: _____

How Did You Hear About Us?*: _____

BILLING INFORMATION

Is billing address the same as patient? Yes No

If different from patient, complete below:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

INSURANCE INFORMATION

Primary Medical Insurance: _____ Member ID: _____

Secondary Medical Insurance: _____ Member ID: _____

Vision Insurance: _____ Member ID: _____

Are you the Primary Policy Holder? Yes No

If someone else is the primary policy holder, complete below:

Policy Holder Name: _____ Relationship: _____ DOB: _____ SSN: _____

REASON FOR VISIT

Reason for today's visit*: Routine Eye Exam Eye Problem Follow-up Contact Lens Exam

Specific concerns or symptoms: _____

OCULAR HEALTH HISTORY

Have you ever been diagnosed with any of the following? (Write details if yes)

Macular Degeneration: _____ Glaucoma: _____ Cataracts: _____

Retinal Detachment: _____ Lazy Eye: _____ Crossed Eyes: _____

Dry Eye: _____ Color Blindness: _____ Other: _____

Eye Surgeries or Laser Procedures:

LASIK/PRK Cataract Surgery Retinal Surgery Glaucoma Surgery Other: _____

Do you wear contact lenses? No Yes Do you wear glasses? No Yes

GENERAL HEALTH HISTORY

Do you have or have you been diagnosed with any of the following?

Diabetes High Blood Pressure Heart Disease Stroke Cancer

Arthritis Asthma Thyroid Disease Kidney Disease High Cholesterol

Autoimmune Disease Depression/Anxiety Migraines Sleep Apnea Allergies

Other conditions: _____

MEDICATIONS, ALLERGIES & LIFESTYLE

Current Medications/Supplements: 1. _____ 2. _____ 3. _____

Medication Allergies: None Yes: _____

Smoke/Tobacco? No Yes: _____ Alcohol? No Yes: _____

Work with computers regularly? No Yes Pregnant/nursing? No Yes N/A

FAMILY HISTORY & DEMOGRAPHICS

Blood relatives with: Glaucoma Macular Degeneration Cataracts Diabetes Blindness Other: _____

Demographics (Optional): Race/Ethnicity: _____ Primary Language: _____

PATIENT ACKNOWLEDGMENT

I certify that the information provided above is true and accurate to the best of my knowledge. I understand that this information is confidential and will be used for healthcare purposes only.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is under 18): _____ Date: _____