Patient Check-In Form:

When you come in for your appointment, please make sure to **bring a copy of any and all insurance cards** for us to scan on file even if we have collected it in the past.

Name: ____ DOB: _____________________

Phone Number:_____________________ Social Security Number:___________________

Address:____ City:__________________

State:_________________ Zip Code:______________

Email: *(to receive access to your medical records)*

____

Medical Insurance

- ➢ Primary Medical Insurance:____
  - Member ID:___________________________ Group ID:________________
  - Primary Account Holder:_________________________ DOB:____________
- ➢ Secondary Medical Insurance:____
  - Member ID:___________________________ Group ID:________________
  - Primary Account Holder:_________________________ DOB:____________
- ➢ Tertiary Medical Insurance:____
  - Member ID:___________________________ Group ID:________________
  - Primary Account Holder:_________________________ DOB:____________

Vision Insurance

- ➢ Primary Vision Insurance *(VSP, Eyemed, Spectera, etc.)*:_________________________
  - Member ID:___________________________ Group ID:________________
  - Primary Account Holder:_________________________ DOB:____________

Interested In New Glasses Today?: **Y / N**

Interested In A Contact Lens Prescription? **Y / N**

Medical or **Routine** visit today? *(Circle one)*

Primary Care Doctor: ____
Primary Care Phone Number: ________________________________

Preferred Pharmacy: ____
Pharmacy Phone Number: ____________________________________

Reason for Visit:
____

Emergency Contact Information:

- ➢ Name (first and last):____________________________________
- ➢ Phone Number:___________________________
- ➢ Please sign below if you give us permission to release your medical information to the provided emergency contact listed above:

____ ______________
Patient Signature or Legal Representative Date

Past General Medical History

Please list all past illnesses, procedures, or diagnosis to help us better serve you in your eye care needs *(please continue on the back of this form if needed)*:

- ➢ Month:______________ Year:_____________
  - ○ Details:____
    ____
- ➢ Month:______________ Year:_____________
  - ○ Details:____
    ____
- ➢ Month:______________ Year:_____________
  - ○ Details:____
    ____

Please indicate below by circling any applicable options, if you have **close family** who has any of the following:

Asthma **Diabetes** **Heart Problems** **High Blood Pressure**

High Cholesterol **Cancer** **Stroke** **Cataracts** **Glaucoma**

Please indicate any medications you are currently taking *(please use the back of this form if needed)*:

- ➢ Name of Medication:____
  - ○ Dosage:____________________________
- ➢ Name of Medication:____
  - ○ Dosage:____________________________
- ➢ Name of Medication:____
  - ○ Dosage:____________________________
- ➢ Name of Medication:____
  - ○ Dosage:____________________________
- ➢ Name of Medication:____
  - ○ Dosage:____________________________

Please circle which option most clearly represents you *(circle one)*:

I am a current smoker **I was a smoker, but I have quit** **I have never smoked**

I drink alcohol **I used to drink alcohol, but I have quit** **I have never drank alcohol**