PATIENT DATA SHEET Today's Date: _____

NAME (Please Print): _____ SEX: _____

ADDRESS: _____ HOME PHONE #: _____

CITY & STATE: _____ ZIP: _____ DATE OF BIRTH: _____

MOTHER'S NAME:_____ FATHER'S NAME: _____

MOM'S CELL #: _____ FATHER'S CELL #: _____

BEST CONTACT #: _____ E-MAIL: _____

PRIMARY INS. COMPANY: _____ ID#: _____

GROUP #: _____ SUBSCRIIBER'S NAME: _____

SUBSCRIBER'S SSN: _____ SUBSCRIBER'S DATE OF BIRTH: _____

PEDIATRICIAN: _____ LOCATION: _____

REFERRED BY: _____ Do you have Secondary Insurance? Yes / No (Circle answer)
(Please write secondary insurance information on the back)

PATIENT'S MEDICAL HISTORY

BIRTH WEIGHT: _____ lbs. _____ oz. Born Premature? _____ If so, how early? _____

Was he/she on oxygen? _____ If so, how long? _____ Any prior surgery? _____

List any medical problems: _____

List any eye problems: _____

List any medications: _____

List any allergies: _____

Date of last eye exam: _____ Doctor: _____ Dilated? _____

FAMILY HISTORY: (List siblings, parents, grandparents, aunts, and uncles with the following)

Crossed Eyes: _____ Cataracts: _____ Glaucoma: _____

Other Eye Problems (including glasses): _____

Heart Disease: _____ Cancer:_____ High Blood Pressure: _____

***** The Subscriber's information must be completed in full prior to being seen. If you do not know the policy holder's SSN, please indicate that you are using the spouse's SSN. *****