

Eagle Rock Eyecare: Patient Intake Form

First Name:

Middle Name:

Last Name:

Suffix:

Date of Birth:

Sex:

SSN:

Occupation:

Phone:

Email:

Address:

City:

State:

Zip:

Vision Insurance, Policy #, Holder Name & DOB:

Medical Insurance, Policy #, Holder Name & DOB:

Reason for Visit:

Last Eye Exam (Mo/Yr):

Wear Glasses? Y N

Wear Contacts? Y N

Previous eye injury or surgery (include year):

Medical conditions (include year diagnosed):

T1 Diabetes T2 Diabetes Hypertension High Cholesterol Anemia Other: _____

Medications (prescribed or over-the-counter):

Allergies (medications, environmental, etc.):

Family history of glaucoma / macular degeneration / other eye disease & who:

Smoke tobacco? Current Former Never

Drink alcohol? No Yes - frequency: _____

Patient (or Guardian) Signature: _____ **Date:** _____