PATIENT INFORMATION – Please complete **all** information. Please print

Patient's Last Name	First Name	Middle Initial	☐ Male ☐ Female	Date of Birth (MM/DD/YY)
Home Address		**City**	**State**	**Zip/Postal Code**
Primary Phone Number (Best # to be reached) ( )	**Alternative Phone Number** ( )	**Employer**		
Insurance Company Name	**Insurance member ID number**	**Last 4 SSN**	**Occupation**	
E-mail (to be used for remainder)		▪ I have reviewed the office privacy policy (HIPAA). ▪ I understand full payment is due at the time of service. ▪ No personal checks are accepted.		

(If patient is under 18, Parent/legal guardian signature is required by law).

Signature: X____ **Date:**_____/_____/________

PATIENT HISTORY – Please complete **all** information

✦ Primary reason for today's visit ____

✦ Date of last eye exam: ________________ By Dr. ____________________ Age of current glasses ______________________

✦ Name of primary physician: ______________________________ Date of last medical exam ______________________

✦ Have you visited this office (Eyexam of Peachtree City) before? ☐Yes ☐No If yes, when:______________________

✦ Have you had dilation or retinal photography before? ☐Yes ☐No If yes, when: ______________________

✦ Currently pregnant? ☐Yes ☐No If yes, how far along: ______________________

✦ Please check any/all that apply:

	Self	*Relative*	*No one*		*Self*	*Relative*	*No one*		*Yes*	*No*
Glaucoma	_____	_____	_____	Thyroid Problems	_____	_____	_____	Dryness or pain in eyes	____	____
Cataracts	_____	_____	_____	Asthma	_____	_____	_____	Blurred Vision	____	____
Diabetes	_____	_____	_____	Heart Disease	_____	_____	_____	Frequent Headaches	____	____
Retinal Disease	_____	_____	_____	Lung Disease	_____	_____	_____	Double Vision	____	____
High Blood Pressure	_____	_____	_____	Eye Disease	_____	_____	_____	Eye Infection	____	____
Macular Degeneration	_____	_____	_____	Eye Surgery	_____			Elevated Cholesterol	____	____

✦ Are you being treated for any additional medical conditions? ☐Yes ☐No If yes, what:______________________

✦ List all medications you are taking: ____

✦ List any medications you are allergic to: ____

✦ Do you experience the following:
Floaters ☐Yes ☐No Any new? ☐Yes ☐No Any worse lately? ☐Yes ☐No
Flashes ☐Yes ☐No Any new? ☐Yes ☐No Any worse lately? ☐Yes ☐No

✦ Have you had any:
Head Injuries ☐Yes ☐ No If yes, when: ____
Eye Injuries ☐Yes ☐ No If yes, when: ____

✦ Do you work on a computer? ☐Yes ☐No If yes, how many hours a day? ______________

✦ **Dilation** ☐Yes ☐No **Optomap** ☐Yes ☐No **X**______________________________________

CONTACT LENS INFORMATION (Fitting & Follow-up must be completed within 1 month in order to purchase contacts)

✦ Have you ever worn contact lenses? ☐Yes ☐ No ✦ Are you interested in updating your annual contact lens prescription today? ☐Yes ☐No
(In State of GA, contact lens Rx expires 1year after eye examination.)

✦ If you wear contact lenses now, please check all that apply:

Type: ☐Hard ☐Gas Perm ☐Soft ☐Disposable ☐Astigmatism (toric) ☐Bifocal ☐Monovision
Replacement Frequency: ☐Daily ☐2 Week ☐monthly ☐quarterly ☐ yearly other________________

How often do you sleep overnight in your contact lens? ____