

Glendale Optometric Center

Patient's Name _____ **Today's Date** _____

Dr. Mr. Mrs. Ms. Miss _____

Address _____ Apt. _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____

Cell Phone (_____) _____ Email Address _____

Date of Birth ____ / ____ / ____ Social Security Number _____

Whom may we thank for referring you to our office? _____

Employer (or school) _____ **occupation (or Grade)** _____

Vision Insurance

Primary _____ Subscriber _____ Member ID# _____

Secondary _____ Subscriber _____ Member ID# _____

Medical Insurance (Provide Insurance Cards)

Primary _____ Subscriber _____ Member ID# _____

Secondary _____ Subscriber _____ Member ID# _____

Parent or

Person Responsible for account _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____

In Case of Emergency, Contact:

Name _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Current Medications

Allergy to Medications

Personal/Family Medical History

Cardiovascular	No Yes	Glaucoma	No Yes
Ear/Nose/Throat	No Yes	Cataracts	No Yes
Respiratory	No Yes	Macular Degeneration	No Yes
Gastrointestinal	No Yes	Eye Injury	No Yes
Genitourinary	No Yes	Retinal Tear/Detachment	No Yes
Arthritis/Muscular	No Yes	Blindness	No Yes
Skin Disorders	No Yes	Amblyopia/Strabismus	No Yes
Neuro/Psychological	No Yes	Eye Surgery	No Yes
Diabetes	No Yes	Corneal Ulcer/Abrasion	No Yes
Thyroid	No Yes	Bleeding Tendency	No Yes
Cancer	No Yes	Headaches	No Yes
High Blood Pressure	No Yes	Dry Eyes	No Yes

Other _____

Do you use Cigarettes/Tobacco? _____ Alcohol? _____

Other Substances? _____

Name of Family Physician _____

When was your last eye exam? _____

Were you dilated? Yes No

Do you have trouble reading signs at night? Yes No

Do you have trouble with bright sunlight? Yes No

Do you have prescription sunglasses with UV protection? Yes No

Do your eyes burn, itch or tear excessively? Yes No

How many hours a day do you spend on a computer? _____

How many hours a week do you spend outdoors? _____

Do you wear contact lenses? Yes No

What kind? _____

Solutions? _____

Are you interested in contact lenses? Yes No

Are you interested in Lasik surgery? Yes No

How do you use your eyes for work? _____

How do you use your eyes for hobbies? _____

I authorize the release of payment for Medical benefits directly to **Glendale Optometric Center** and the release of any medical information necessary to process all insurance claims.

I understand that the dilating eye drops used as part of the examination may blur vision for an hour or longer and make it unsafe to drive. I will not attempt to drive until I feel safe to do so.

I acknowledge that I am responsible for payment of all services and materials in the event that my insurance denies any claims.

Patient's/Guardian's Signature: _____ Date: _____