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PATIENT INFORMATION Date _____

Last Name _____ First _____ MI _____

DOB _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Phone: Home _____ Work _____ Cell _____ Email _____

Employer _____

PARENT/GUARDIAN INFORMATION

Last Name _____ First _____ MI _____

DOB _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Phone: Home _____ Work _____ Cell _____ Email _____

Employer _____

How did you hear about our office? _____

VISION INSURANCE

Plan Name _____ ID #/SSN _____

Policy Holder Name _____

MEDICAL INSURANCE

Plan Name _____ ID #/SSN _____

Policy Holder Name _____ DOB _____

Secondary _____

Primary Care Physician _____

Address _____

Phone Number _____ Fax Number _____

SOCIAL HISTORY

Do you use tobacco products? YES ☐ NO ☐

If you circled yes, what type of tobacco? _____

For how long? _____

Amount of pack(s)/day? _____

Do you drink alcohol? YES ☐ NO ☐

If yes, how much/often? _____

Do you use illegal drugs?

If yes, type/amount/how long? _____

Please circle if you have been exposed to the following below:

☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Are you pregnant and/or nursing? YES ☐ NO ☐

Do you currently wear glasses? YES ☐ NO ☐

How old is your current pair? _____

Do you currently wear contact lenses? YES ☐ NO ☐

Are you interested in contact lenses? YES ☐ NO ☐

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REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas?

CONSTITUTIONAL

Fever, Weight loss/gain	YES ☐	NO ☐

INTEGUMENTARY (SKIN) YES ☐ NO ☐

NEUROLOGICAL

Headaches	YES ☐	NO ☐
Migraines	YES ☐	NO ☐
Seizures	YES ☐	NO ☐
Fainting	YES ☐	NO ☐
Numbness/Tingling	YES ☐	NO ☐

EYES

Loss of vision	YES ☐	NO ☐
Blurry vision	YES ☐	NO ☐
Distorted vision	YES ☐	NO ☐
Double vision	YES ☐	NO ☐
Dry eyes	YES ☐	NO ☐
Discharge	YES ☐	NO ☐
Redness	YES ☐	NO ☐
Sandy, gritty feeling	YES ☐	NO ☐
Itching	YES ☐	NO ☐
Burning	YES ☐	NO ☐
Foreign body sensation	YES ☐	NO ☐
Excess tearing	YES ☐	NO ☐
Glare/light sensitivity	YES ☐	NO ☐
Eye pain/soreness	YES ☐	NO ☐
Chronic infection	YES ☐	NO ☐
Sties	YES ☐	NO ☐
Flashes/floaters	YES ☐	NO ☐

ENDOCRINE

Thyroid disease	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐
Heat/cold intolerance	YES ☐	NO ☐

PSYCHIATRIC

ADD/ADHD	YES ☐	NO ☐
Depression	YES ☐	NO ☐
Nervous	YES ☐	NO ☐
Stress	YES ☐	NO ☐
Memory loss	YES ☐	NO ☐

EARS, NOSE, MOUTH, THROAT

Allergies/Hay fever	YES ☐	NO ☐
Sinus problems	YES ☐	NO ☐
Runny nose	YES ☐	NO ☐
Chronic cough	YES ☐	NO ☐
Dry throat/mouth	YES ☐	NO ☐

RESPIRATORY

Asthma	YES ☐	NO ☐
Chronic Bronchitis	YES ☐	NO ☐
Emphysema	YES ☐	NO ☐
Sleep Apnea	YES ☐	NO ☐
Shortness of breath	YES ☐	NO ☐
Wheezing	YES ☐	NO ☐

VASCULAR

Diabetes	YES ☐	NO ☐
Chest pain	YES ☐	NO ☐
High blood pressure	YES ☐	NO ☐
Elevated cholesterol	YES ☐	NO ☐
Other vascular disease	YES ☐	NO ☐
Chest tightness	YES ☐	NO ☐

GASTROINTESTINAL

Diarrhea	YES ☐	NO ☐
Constipation	YES ☐	NO ☐
Nausea	YES ☐	NO ☐

GENITOURINARY

Kidney/bladder problems	YES ☐	NO ☐
Genital problems	YES ☐	NO ☐

BONES/JOINTS/MUSCLES

Rhematoid arthritis	YES ☐	NO ☐
Osteoarthritis	YES ☐	NO ☐
Muscle/joint pain	YES ☐	NO ☐

LYMPHATIC/HEMATOLOGIC

Anemia	YES ☐	NO ☐
Bleeding problems	YES ☐	NO ☐
Cancer	YES ☐	NO ☐
Lupus	YES ☐	NO ☐

Circle any of the following that YOU have/had:

☐ Lazy eye	☐ Glaucoma	☐ Retinal Disease	☐ Cataracts
☐ Eye injuries	☐ Eye infections	☐ Droopy Eyelids	☐ Prominent Eyes

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MEDICAL HISTORY

Please list all medical conditions: _____

_____

_____

Please list all medications and dosages below.

Medication	Dosage

Medication	Dosage

Are you allergic to any medications? YES ☐ NO ☐

If yes, please list the medication and the reaction you had below:

_____

Have you had any ocular surgeries? YES ☐ NO ☐

If yes, please explain _____

Have you ever been hospitalized, had any surgeries, or broken bones? YES ☐ NO ☐

If yes, please explain _____

FAMILY HISTORY

Please list any family member (maternal/paternal grandparents, parents, siblings, and/or children) living or deceased that have the following conditions

Blindness _____ Arthritis _____

Cataract _____ Cancer _____

Eye turn _____ Diabetes _____

Glaucoma _____ Heart Disease _____

Macular Degeneration _____ High Blood Pressure _____

Retinal Disease _____ Kidney Disease _____

Retinal Detachment _____ Thyroid Disease _____

High Cholesterol _____

Patient Payment Agreement

I request that payment of authorized insurance benefits for any service furnished me be made on my behalf to the office of Great Bridge Eye Care, William C. Holcomb, OD. FAAO. I authorize any holder of medical information about me to release the information needed to determine the benefits payable for related services. I accept responsibility for any unpaid claims that are denied because a correct referral was not provided. In the event that my insurance should not pay for the products or services provided, I agree to be responsible for payment to Great Bridge Eye Care, William C. Holcomb, OD. FAAO. I understand that professional fees, insurance deductibles and co-payments are due at the time of the visit.

Contact Lens Wearers: In most cases contact lenses are not considered “medically necessary” by some insurance plans. Any tests performed to update a contact lens prescription or to refit you with a new lens may not be covered under your plan and will be the responsibility of the patient.

Patient Signature: _____ Date: _____

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