SUMMIT VISION CARE

WELCOME TO OUR OFFICE

Patient Information

Last_____

First_____ MI_____

Street_____

City_____ State_____

Zip_____

Date of Birth_____/_____/_____

Marital Status _____

Sex M F

Please provide at least 2 phone numbers

Home Phone_____

Work Phone_____

Cell Phone_____

Email_____

Occupation_____

Hobbies_____

_____

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

Who may we thank for referring you?

_____

If not referred, how did you hear about us?

- ☐ Internet Search
- ☐ Location/Drove by
- ☐ Insurance List
- ☐ Direct Mail
- ☐ Doctor Referral
- ☐ Yellow Pages
- ☐ Town Event (which one)_____
- ☐ Other_____

Insurance Information

Medical Insurance

Carrier_____

Vision Insurance

Carrier_____

Subscriber Employer _____

Subscriber SSN XXX-XX-_____

Subscriber birth date_____

Do you have?

Diabetes Type: _____ Yes No

High Blood Pressure Yes No

High Cholesterol Yes No

Personal Medical History

Cardiovascular_____

Ear Nose Throat_____

Respiratory_____

Gastrointestinal_____

Urinary_____

Today's Date:_____

Musculoskeletal_____

Skin_____

Neurological_____

Psychiatric_____

Endocrine_____

Hematologic/Lymph_____

Allergic/Immunologic_____

Surgical History_____

_____

_____

Do you have the following?

Dry Eye	YES	NO
Glasses	YES	NO

Contact Lenses: NO YES Type_____

Do you or anyone in your family have the following?

If yes, please list which relative

Glaucoma _____

Cataracts_____

Macular Degen._____

Retinal Disease_____

Other Disease_____

Blindness_____

Strabismus (crossed eyes)_____

Amblyopia (lazy eye) _____

Diabetes_____

Cancer _____

Heart Disease_____

Other_____

Social History

Tobacco Use	YES	NO
Drugs	YES	NO
Alcohol	YES	NO

Medications: please include any Rx or OTC

_____

_____

_____

Medication Allergies_____

_____