Branford

Family Vision Care

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Doctor of Optometry

WELCOME TO THE OFFICE

Name of Patient:_____Date:_____

Patient's Date of Birth: _____ Social Security#:_____

Address:_____City:_____ State:_____ Zip:_____

Home Telephone:_____ Work:_____Cell:_____

Email Address:_____

Place of Employment:_____Present Position:_____

If minor, parent or guardian's name:_____

Insurance Information

Please indicate if you are covered by any of the following Insurance Plans:

- ❑ Aetna
- ❑ Blue Cross
- ❑ Cigna
- ❑ Connecticare
- ❑ Davis
- ❑ Eyemed
- ❑ HealthNet
- ❑ Husky
- ❑ Medicaid
- ❑ Medicare
- ❑ Oxford
- ❑ Spectera
- ❑ United Health Care
- ❑ VSP
- ❑ Other_____

Insured's Name:_____Insured's Date of Birth: _____

Insurance Identification # _____Group # _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child/Dependent

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired ☐ Student

Patient's Status: ☐ Single ☐ Married

How did you hear about our office? ☐ Yellow pages ☐ Insurance Co. referral ☐ Convenient location

Recommended by_____

When was your last eye exam?_____

Are you interested in Lasik Vision Correction? Yes ☐ ☐ No

Have you ever worn contact lenses? ☐ Yes ☐ No

Are you interested in contact lenses? ☐ Yes ☐ No

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Have you recently noticed any of the following?

	Yes	No		Yes	No
Blur at far	___	___	Ocular itchiness	___	___
Blur at near	___	___	Ocular redness	___	___
Double vision	___	___	Ocular pain	___	___
Headaches	___	___	Ocular discharge	___	___
Floaters	___	___	Problem night driving	___	___
Flashes of light	___	___	Eyes feel strained	___	___
"Halo" effect around lights	___	___	Extreme sensitivity		
Ocular dryness	___	___	to light	___	___

Is there any other problem(s) you may have noticed with your vision? _____

_____

When was your last physical exam?_____

Name & city of your family physician?_____

Do you presently or have you ever had a history of:

	Yes	No		Yes	No
Glaucoma	___	___	Stroke	___	___
Cataracts	___	___	Elevated Cholesterol	___	___
Retinal Disease	___	___	Cancer	___	___
Corneal Disease	___	___	Strabismus		
Retinal detachment	___	___	(an eye turning in/out)	___	___
Hypertension	___	___	Ambloypia		
Diabetes		___ ___	(lazy eye)	___	___

Have you ever had any serious injuries to your eyes or head?_____

Have you ever had surgery on your eyes?_____

Do you have a history of allergies, asthma or hayfever?_____

List any medication you are presently taking?_____

_____

Is there any history in your immediate family of :

	Yes	No		Yes	No
Hypertension	___	___	Cataracts	___	___
Diabetes		___	___ Retinal Disease	___	___
Glaucoma	___	___	Blindness	___	___
Retinal Detachment	___	___	Other Eye Disease_____		