Date:_____

eyeguys OPTICAL

NEW OR EXISTING PATIENT

❒ Vision Exam

❒ Medical Exam

❒ Larry Breazeal, O.D.

Emp. Initials: _____

PATIENT INFORMATION

Patient's Last Name	First (legal name)	Middle Init.	❒ Dr. ❒ Ms. ❒ Mr. ❒ Mrs.	Marital Status (for billing purposes) ❒ Div ❒ Sep ❒ Mar ❒ Sgl ❒ Wid
Nickname	Date of Birth (m/d/y)	❒ Male ❒ Female	Social Security (for billing purposes)	Person with Financial Responsibility
Mailing Address		City	State	Zip
Home Phone	Day Phone	Cell Phone	Email Address	Employer/Occupation

PATIENT HISTORY

#1 Do you have problems with:

❒ Redness, itching, tearing, or burning

❒ Routine headaches, double vision, or sudden vision loss

❒ Floaters or light flashes

❒ Blurriness or eye discomfort

Have you worn glasses before? ❒ Yes ❒ No

Have you worn contacts Before? ❒ Yes ❒ No

Do you smoke? ❒ Yes ❒ No

#2 Have you ever had problems with the following:

❒ Allergies
❒ Arthritis
❒ Asthma
❒ Blood/ Cholesterol
❒ Cancer
❒ Diabetes
❒ Heart Disease
❒ High Blood Pressure
❒ Immune/ Lymphatic
❒ Kidney Problems
❒ Mental State/ Neurologic
❒ Skin/ Integumentary
❒ Stomach/ Intestinal
❒ Thyroid
❒ Eye Disease, Surgery or Injury
❒ Pregnant Now

#3 List ANY Medications you take, including over-the-counter medicines.

❒ None

Allergies to Medication? ❒ Yes ⇒ ❒ No

#4 List any disease that tends to run in your family.

❒ None

Last Eye Exam – when/where?	Primary Care Physician.	How did you hear about us?	Sports/Hobbies.

Thank you for filling out this form!

For Office Use		Recall, 12 mo.
Vitals: BP _____ / _____ Pulse _____ Height _____ Weight _____ VA:	❒ Demographics ❒ HIPPA ❒ Call/Check Insurance ❒ Letter to Primary MD ❒ Rx Written/Printed ❒ Set Recall ❒ Coding ❒ Fee Slip ❒ Chart Done ❒ Chart Scanned	RTC: ❒ 92499 ❒ 92250 ❒ 992____ ❒ 92310 ___ ❒ 92015 ❒ 9208__ ❒ 9213___ ❒ 920____ ❒ 367.1 ❒ 367.21 ❒ 367.4 ❒ 367.0 ❒ 375.15 ❒ 224.6 ❒ 366.16 ❒ 365.01 ❒ 362.31 ❒ 379.24 ❒ _____ ❒ _____