



Logan Eye Care

for the sincere visual experience

Patient Information (Please Print)

Today's Date: ____/____/____

Miss Mrs. Ms. Mr. Dr. (Please Circle)

E-mail Address: _____

Patient's Name: _____ Date of Birth: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Minor Married Single Divorced Widowed (Please Circle) SS Number _____

If patient is a minor: Mother's Name: _____ Father's Name: _____

Employer: _____ Occupation: _____

Student: Yes or No Grade: _____ School: _____

How or by whom were you referred to our office: _____

Primary Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance:

Primary Insurance Provider: _____ Phone Number: _____

Policy/ID Number: _____ Group Number: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder SS Number: _____ Policy Holder DOB: ____/____/____

Policy Holder Employer: _____

Responsible Party:

Guarantor/Name of person responsible for this account: _____

Relationship of Guarantor to Patient: Self Parent Other (Please Circle)

Authorization:

I certify that I have read and understand the information on the FRONT and BACK of this form, and have answered the questions accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand and agree to be financially responsible of all services rendered on my behalf or my dependents.

X

Signature of patient or parent (if minor)

Date

Date of last eye exam: ____/____/____

Doctor: _____

Do you wear glasses: Yes or No

How old are the lenses? _____

Do you wear contact lenses: Yes or No

If yes, what kind? Soft Hard RGP Disposable Daily Wear Extended Wear

Are you interested in contacts? Yes or No

Are you interested in Laser Vision Correction? Yes or No

Do you have or had any of the following medical conditions? If yes, please explain, including the date, diagnosis and **ANY MEDICATIONS YOU ARE TAKING.**

<u>Medical Condition</u>	<u>Medications</u>
Y N Eye Injuries: _____	_____
Y N Eye Surgery: _____	_____
Y N Loss of Vision: _____	_____
Y N Glaucoma: _____	_____
Y N Macular Degeneration: _____	_____
Y N Cataracts: _____	_____
Y N Retinal Detachment: _____	_____
Y N Diabetic Eye Disease: _____	_____
Y N Lazy Eye: _____	_____
Y N Dry Eyes: _____	_____
Y N Legal Blindness: _____	_____
Y N Any other eye disease: _____	_____
Y N Seasonal or general allergies: _____	_____
Y N Diabetes _____	_____
Y N Arthritis, Lupus, other autoimmune disease: _____	_____
Y N Heart disease or chest pain: _____	_____
Y N High Blood Pressure: _____	_____
Y N Elevated Cholesterol: _____	_____
Y N Thyroid Condition: _____	_____
Y N Cancer: _____	_____
Y N Asthma: _____	_____
Y N Anxiety, Depression: _____	_____
Y N Sleep Disorder: _____	_____

Social History:

- Y N Do you have difficulty driving during the day?
- Y N Do you have difficulty driving at night?
- Y N Do you drink alcohol? How many drinks a day? _____
- Y N Do you smoke? How many packs a day? _____
- Y N Have you ever had a blood transfusion? Date: _____

Do you ... (Please circle Y or N)

- Y N Work on a computer? If yes, how many hours a day? _____
- Y N Have prescription sun glasses? If yes, how old are the lenses? _____
- Y N Participate in recreational sports? If yes, please list: _____
- Y N Do you do a lot of reading? If yes, how many hours a day? _____
- Y N Want information on Laser Vision Correction?