DEAN OPTICAL

PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally seperated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group !D#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child*

Secondary Medical Insurance

Secondary Medical Insurance Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy#/Group !D#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

DEAN OPTICAL

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently wear Glasses?

Currently wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or have been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eyes	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experience, or have experienced, any of the following? Check all that apply.

Blurry Vision *near or distance*

Burning

Discharge

Double Vision

Dryness

Excess Tearing/Watering

Eye Infection

Eye Pain or Soreness

Floaters or Spots

Halos

Headaches

Itching

Light Flashes

Light Sensitivity

Redness

Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or have been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?