

Scarborough Family Eyecare

Patient Information Sheet

Date _____

General Information:

Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____ Email Address _____ Tourist
Date of Birth _____ Preferred Name _____ (Jim, Rick, etc.) Male / Female Soc. Sec. No. ____ - ____ - ____
Current Occupation or School Grade _____ Employer or School _____ Work Phone (____) _____
Children's Custodial Parent or Legal Guardian _____ Spouse _____ OK to be contacted at work

Insurance Information:

* We can make a photocopy of your insurance card if you have it with you.

Policyholder's Name _____

Primary Vision Insurance _____ Contract ID # _____ Policyholder's Birthdate _____
Secondary Vision Insurance _____ Contract ID # _____ Policyholder's Birthdate _____
Medical Insurance _____ Contract ID # _____ Policyholder's Birthdate _____
Policy Holder's Soc. Sec. No. ____ - ____ - ____ Policyholder's Employer _____ Employer's Phone No. _____

New Patient Information:

Date of Last Eye Examination _____ Were your eyes dilated? Yes No Previous Eye Doctor & Office Location _____
How did you hear about us? Friend or Family _____ Yellow Pages Insurance Co. Website Office Location/Sign Other _____

** We give a thank you gift to patients that refer others to us. Please make sure if someone referred you to us that you list their name above.

Vision Information:

Do you wear glasses? Yes No Do you wear contacts? Yes No Are you interested in trying contacts? Yes No
Have you had any eye surgery or LASIK? Yes No Any personal or family history of: Glaucoma Cataracts Macular Degeneration Other Eye Disease

Medical Information:

Do you have problems with any of these systems? (Please circle yes or no)

Stomach / Colon	Yes / No	Nerves	Yes / No	Glands / Thyroid	Yes / No
Ears / Nose / Throat	Yes / No	Kidneys	Yes / No	Blood	Yes / No
Heart	Yes / No	Muscles / Bones	Yes / No	Allergies	Yes / No
Breathing	Yes / No	Skin	Yes / No	Headaches	Yes / No
Diabetes	Yes / No	High Blood Pressure	Yes / No	Other	Yes / No Details: _____

Please list current prescription medications: (We can make a copy if you have a list with you) _____

Allergies to any medications? Yes / No If yes, please list: _____

Lifestyle Information:

Please indicate any of the following that pertain to you:

Work on computer Drive a lot at night Work outside in the sun Hazardous job; construction etc. Read for work/pleasure
Shooting sports; hunting etc. Water sports; fishing etc. Team sports; baseball etc. Other special vision needs _____

Pupil Dilation:

To perform a comprehensive eye examination it may be necessary for the doctor to dilate your pupils with eye drops.
The side effects of pupil dilation can last for several hours and include: sunlight sensitivity and possible blurred vision.
Some patients prefer to have someone drive them home following pupil dilation.

If found necessary, I prefer to be dilated: Today Some other day Prefer not to be dilated

Responsibility for Payment:

We will gladly bill any insurance that we participate with. If we are confident in what your out-of-pocket expense will be, we expect payment for that at the time of service.

Person Responsible for Payment: _____ Relationship to Patient _____