Guardian: _____ **Date:**

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ **Sex:** _____

E-Mail: _____

Occupation: _____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

Emergency Contact Name and Phone:

_____

Approx. Date of Last Eye Exam: _____

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Double vision
- ☐ Sandy/Gritty
- ☐ Spots or shadows
- ☐ Diabetes eye check
- ☐ Medical eye check
- ☐ Other...

Which Eye? ☐ Right eye ☐ Left ☐ Both eyes

How long has it bothered you?

- ☐ Started today
- ☐ 1-2 days
- ☐ 3-7 days
- ☐ 1-2 weeks
- ☐ 2-4 weeks
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ Over 6 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right

Left

Contacts: Right

Left

Medical Doctor(s):

Eyeconic Eye Center

E-mail: eyeconiceyecenter@gmail.com
http://www.eyeconiceyecenter.com

Race
- ○ American Indian or Alaska
- ○ Asian
- ○ Black or African-
- ○ Native Hawaiian or Other Pacific
- ○ Other
- ○ Unknown/undetermine
- ○ White

Ethnicity
- ○ Not Hispanic or Latino 2186-5
- ○ Hispanic or Latino 2135-2

Language ☐ English ☐ French ☐ Mandarin ☐ Other... ☐ Spanish ☐ Japanes ☐ Unknown

Smoking
- ○ Ex-smoker
- ○ Heavy tobacco smoker
- ○ Light tobacco smoker
- ○ Never smoked tobacco
- ○ Tobacco Smoking Consumption unknown

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Participate in a flex spending account? ☐ Y ☐ N