# BEAVER DAM EYE CARE PATIENT INFORMATION

Name_____ Today's Date_____
Address_____ Birth Date_____ Age_____
_____ Home Phone_____
_____ Cell Phone_____
Email_____ Work Phone_____
Occupation_____ Employer_____
Emergency contact/telephone_____
Policy Holder/Responsible Party_____ Birth Date_____

## What is your reason for seeking vision care at this time? _____

_____

Last Eye Exam_____ When is the last time your eyes were dilated? _____
Do you wear contacts? Yes / No Are there times you'd like to wear contacts? Yes / No

## HEALTH HISTORY

Name of family doctor? _____ Date of last tetanus shot_____
Do you have or have you had any of the following?

| | | |
|---|---|---|
| _____asthma | _____head injury | _____glaucoma |
| _____cancer/tumor | _____headaches | _____cataracts |
| _____cholesterol high | _____alcohol use | _____eye infection |
| _____diabetes | _____tobacco use | _____eye surgery |
| _____high blood pressure | _____seasonal allergies | _____spots/ flashes of light |

_____medication allergies _____

**CURRENT MEDICATIONS**_____

_____

_____

## FAMILY HISTORY

Has anyone in your family had any of the following?...(If so, whom?)

| | |
|---|---|
| _____diabetes | _____glaucoma |
| _____cancer | _____macular degeneration |
| _____heart disease | _____retinal disease/detachment |
| _____high blood pressure | _____cataracts |

How did you hear about Beaver Dam Eye Care? _____

**PATIENT FINANCIAL RESPONSIBILITY**

I AUTHORIZE BEAVER DAM EYE CARE TO BILL MY INSURANCE COMPANY FOR CHARGES PERTAINING TO MY CARE. I AGREE TO ASSUME RESPONSIBILITY OF FULL PAYMENT PENDING ANY REMAINING BALAMCE THAT IS NOT COVERED BY MY INSURANCE CARRIER.

**Patient/Guardian Signature _____ Date_____**