peepers
EYE CARE CENTER

In order to provide you with the best care, please complete the following information. Our staff will be glad to assist you if you have any questions.

Today's Date:_____/_____/_____

Personal Information

Name:_____ Date of Birth:_____ Age:_____
Current Address:_____
City:_____ State:_____ Zip Code:_____
SSN#:_____ Guardian Name: _____

Occupation: _____ Marital status: _____ Gender: _____
Who can we thank for referring you to our office? _____

Contact Information

Home phone:_____ Cell phone:_____

Work phone:_____ Email address:_____

Insurance Information

Insurance Co.: _____
Member ID: _____ Group ID: _____
Who is the primary on the account? _____ Their DOB: ____/____/_____

Medications/ Allergies

Please list any medications you are taking and the dosage:
_____
_____
_____
Please list any allergies to medications you are aware of:
_____
_____
Please list any allergies you have: _____
_____

(PLEASE SEE BACK)

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Medical Information

Please place a check in the box if the described condition applies to you:

Medical Health	Yourself ✓	Family, if yes who?
High blood pressure		
History of stroke		
Diabetes (if yes what type)		
High cholesterol		
Eye Injury or Surgery		
Arthritis		
Thyroid condition		
HIV/AIDS		
Glaucoma		
Loss of vision/Blindness		
Macular Degeneration		
Amblyopia or Strabismus (turned eyes)		
Cataracts		
Flashing lights / Floaters		
Retinal detachment		
Macular degeneration		
Other:		

Vision History

Would you like a prescription for: (circle) **GLASSES** **CONTACT LENSES**

Have you worn glasses: (circle) **YES** **NO** If so, how old are your current glasses: _____

Have you worn contacts: (circle) **YES** **NO** If so, what brand/type of contacts? _____

Who is your medical doctor? _____ Date of last physical: _____
Who is your previous eye doctor? _____ Date of last eye exam: _____
Any other vision issues you would like your Doctor to know?

_____