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Family and Developmental Optometry
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New Patient Information

Date: _____

Welcome to our office! For first name us to effectively meet your vision and eye health needs, please complete the following:

Patient Information

Legal Last Name _____ First_____ MI _____
Preferred Name _____ Date of Birth_____

Sex assigned at birth _____ Gender _____ Pronouns _____

Home Address_____ City_____ Zip_____

Phone No. Home( )_____ Work( )_____ Cell( )_____

Email Address _____

We send out upcoming and annual appointment reminders via text and email. We also may send periodic news (like trunk shows and sales) regarding our practice. We will never release your information to outside parties.

May we contact you for:

Appointments via: (circle all that apply) *home work cell text email* News via email: *Yes No*

Occupation (or Grade)_____ Employer (or School)_____

If patient is a minor: Name of Parent/Guardian _____
Your relationship to patient (circle) *Mother Father Other:*

Who may we thank for referring you to our office? _____

Vision and Health Insurance Information

Vision Care Insurance Carrier_____ Member ID#_____

Medical Insurance Carrier_____ Member ID#_____

Member Name:_____Member Date of Birth_____

Do you have Medicare? *Yes No* MediCal? *Yes No*

Method of payment you will use today (circle) *Cash Check Credit Card Care Credit*

I have read and understand the Notice of Privacy Practices for the office of Hollywood Vermont Optometrics.

_____ _____
Signed (your name) Date

-Please see other side-

Patient Name:_____

Medical/Vision Information

Approximate Date of your last Eye Exam (month/year)_____

Briefly state your chief eye or vision concerns for your visit today _____
_____

Do you experience symptoms like dry, itchy, watery, burning eyes: *Yes* *No*

Do you experience symptoms of headache or migraines? *Yes* *No* How severe and often? _____

Do you use a computer or digital device (tablet, phone)? *Yes* *No* How many hours a day? _____

Do your eyes feel tired, sore or uncomfortable when reading or do you ever lose your place or concentration when reading? *Yes* *No*

Do you wear contact lenses? *Yes* *No* If no, are you interested in Contact Lenses? *Yes* *No*

Do you wear sunglasses? *Yes* *No* If yes, what type(s): *Prescription* *Non-Prescription* *Clip-on*

Do you participate in any activities that put your eyes at risk for injury? *Yes* *No*
(i.e. racquetball, car repair, power tools, home repair etc.)
If yes, do you wear safety glasses? *Yes* *No*

Would you like information or are you interested in any of the following? (Please check)

- ❑ Vision Therapy for learning related visual problems
- ❑ Treatment to reduce or control nearsightedness progression (myopia control)
- ❑ Dry eye / Ocular aesthetics treatment
- ❑ Occupational / Workspace eyeglasses
- ❑ Refractive/Laser Eye Surgery to reduce your dependence on glasses/contact lenses

Primary Care Physician Name:_____ Date of Last Physical: _____
Address/Phone:_____
Medical Conditions:

Diabetes	Self	Family/Who_____
Hypertension	Self	Family/Who_____
High Cholesterol	Self	Family/Who_____
Thyroid	Self	Family/Who_____
Glaucoma	Self	Family/Who_____
Macular Degeneration	Self	Family/Who_____
Cataracts	Self	Family/Who_____
Strabismus	Self	Family/Who_____
Amblyopia	Self	Family/Who_____
Other	Self	Family/Who_____

Do you smoke?_____ How much?_____
Medications:_____

Medication Allergies:_____

Other Allergies (food/environmental):_____

Patient Signature:_____Date:_____

Parent/Guardian Signature if Patient is a Minor:_____