



**Adult Patient Information Form**

Please complete the entire form below.

If a question does not apply to you, please enter "NA" as your answer.

Choose the location of your scheduled appointment:  Tyler  Longview  Athens  Henderson

**Patient Information**

Mr.  Mrs.  Miss  Ms.  Dr.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address/P.O.Box/Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

If retired, when and where: \_\_\_\_\_

**Spouse's Information**

Spouse's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

If retired, when and where: \_\_\_\_\_

**Insurance Information**

Primary Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Primary Insurance Policyholder: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Secondary Insurance Policyholder: \_\_\_\_\_

Additional Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Additional Insurance Policyholder: \_\_\_\_\_

I declare that I have no insurance policies other than what is listed above: \_\_\_\_ Yes \_\_\_\_ No

**If your appointment is scheduled due to a Workers' Compensation injury:**

Date of Injury: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Employer Contact Name: \_\_\_\_\_

**If referred by a Medical Doctor or Optometrist, please list:**

Referring Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

List any previous eye surgeries along with all other surgeries: \_\_\_\_\_

\_\_\_\_\_

**Communication**

\_\_\_ You may leave confidential clinical/surgical information on my answering machine or voicemail

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

\_\_\_ You may leave confidential clinical/surgical information on the following additional methods of communication, ie: cell phone, voice mail at work, etc...

\_\_\_\_\_  
Patient/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

**Medical Information**

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Optometrist: \_\_\_\_\_ Family Dr./PCP: \_\_\_\_\_

**Personal Medical History**

Do you wear glasses? \_\_\_ Yes/type \_\_\_\_\_ \_\_\_ No

Do you wear contacts? \_\_\_ Yes/type \_\_\_\_\_ \_\_\_ No

Allergies to medications: \_\_\_\_\_

Eye medications/drops: List all eye drops or eye medications that you take including the dosage and strength: \_\_\_\_\_

List all other medications, vitamins and/or herbs that you take. Please include the dosage and strength of each: \_\_\_\_\_

Have you been diagnosed with any of the following:

- |                             |                          |
|-----------------------------|--------------------------|
| ___ Blindness               | ___ Diabetes             |
| ___ Glaucoma                | ___ High Blood Pressure  |
| ___ Cataracts               | ___ Heart Disease        |
| ___ Retinal Disorder        | ___ Asthma               |
| ___ Crossed Eyes/Strabismus | ___ Thyroid Disease      |
| ___ Lazy Eye/Amblyopia      | ___ Autoimmune Disorders |
| ___ Cancer                  | ___ Other: _____         |

List any previous eye surgeries along with all other surgeries:  
\_\_\_\_\_

**Family Medical History**

Please check all that apply, and indicate their relationship to you:

<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Retinal Disorder _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Crossed Eyes/Strabismus _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Lazy eye/Amblyopia _____	<input type="checkbox"/> Autoimmune Disorders _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Other: _____

**Social History**

Current Occupation: \_\_\_\_\_

Do you use tobacco products?  Yes  No

Do you drink caffeine?  Yes  No

Do you drink alcohol?  Yes  No  Occasionally  Daily

Do you use recreational drugs?  Yes  No  In the past Type: \_\_\_\_\_

Please list your pharmacy or choice of pharmacy below:

- This information will be added into your electronic medical records.

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address or approximate location: \_\_\_\_\_