COCHITUATE EYE CARE – NEW PATIENT FORM Date: _____

Name_____ Date of Birth_____

Occupation_____ Social Security #_____

Do you wear glasses?_____ # years_____ Age of current glasses_____

Do you wear contact lenses_____ # years_____

When was your last eye exam?_____ By whom?_____

Any trauma/injury to your eyes? _____ If so, what/when?_____

Have you or a blood relative ever had any of the following?

ISSUE	YOU	RELATIVE (Who?)
Glaucoma……..	_____	_____
Macular Degeneration……..	_____	_____
Retinal Detachment……..	_____	_____
Cataract…….	_____	_____
Uveitis/Iritis/Inflammation……...	_____	_____
Amblyopia (lazy eye)……...	_____	_____
Diabetes……	_____	_____
Hypertension…….	_____	_____
Heart Disease…….....	_____	_____
Anemia…….	_____	_____
Thyroid Problem……...	_____	_____
Arthritis…….....	_____	_____
Sinusitis…….	_____	_____
Asthma……..	_____	_____
Headaches/Migraines……	_____	_____
Cancer (Specify Type)……..	_____	_____
High Cholesterol / Triglycerides…...	_____	_____
Learning Challenges……..	_____	_____
Headaches……..	_____	_____
Eye pain…….	_____	_____

Do you ever see double?_____

Do you ever see spots floating by in front of you?_____

Do you ever see flashes of light?_____

Do you have any problem with color vision?_____

How many hours per day do you do close work?_____ Computer time?_____

Primary Care Physician_____ Phone#_____

All medications/vitamins/OTC medications:_____

_____

_____

Do you smoke?_____ # years_____ # packs per day_____

Do you drink alcoholic beverages?_____ # years_____ #drinks per day_____

List allergies to medications_____

List environmental allergies_____

Address:_____

Street City State Zip

Phone # - Home_____ Cell_____

Email_____

Insurance Plan_____ ID #_____

Subscriber_____Subscriber Date of Birth_____

By signing my name below, I acknowledge that I know I am responsible for all non-covered insurance costs provided to me at Cochituate Eye Care at the time services are rendered.

I agree to the office policy of a $25.00 fee incurred for not cancelling an appointment within 24 hours, or for not showing up for a regularly scheduled appointment.

Printed Name_____

Signature_____ Date_____