Palisade Eye Associates

Today's Date _____ Chart Number _____

Last Name _____ **First Name** _____ **MI** _____

Address _____ Apt# _____ **Zip Code** _____

SSN # _____ **Date of Birth** _____

Telephone (Home) _____ (Cell) _____ (Work) _____

Email Address : _____ @ _____ . _____

Name of Primary Doctor _____ Date of Last Medical Exam _____

Name of Pharmacy and Location _____

Primary Health Insurance _____ Secondary Health Insurance _____

Are you the primary insured for the insurance(s)? **YES / NO** ***if NO, please enter policy holder's information below***

Policy Holder's Name _____ DOB _____ SS # _____

Relationship to Insured **SELF** **SPOUSE** **PARENT** **OTHER** _____

Do you have one of these VISION PLANS? ☐ **Vision Service Plan (VSP)** ☐ **Eye-Med** ☐ **Blue View Vision**

Do you have any of the following medical conditions? Please place an X in all that may apply:

Allergies (including medications) ☐ If yes, list _____

Diabetes? ☐ **Year of Diagnosis** _____ **High Blood Pressure?** ☐ **High Cholesterol?** ☐

Arthritis? ☐ **Heart Disease?** ☐ **Other Health Problems?** _____

What MEDICATIONS are you currently taking _____

_____

Do you smoke cigarettes? ☐ **Do you socially drink alcohol?** ☐ .

Have you had any operations? ☐ **Kind?** _____ **When?** _____

Have you had any eye operations? ☐ **Type?** _____ **What Year?** _____

Have you ever had an eye injury? ☐ **Kind** _____ **When?** _____

Any Other Eye Problems? ☐ **What Kind?** _____

Do you wear glasses? ☐ **Contact Lenses?** ☐ **What Brand?** _____

Are you currently using any eye drops? ☐ ***If so, please list*** _____

Family History (Does anyone in your family have any of the below listed?)

High Blood Pressure ☐ Relation _____ **Macular Degeneration** ☐ Relation _____

Diabetes ☐ Relation _____ **Retinal Detachment** ☐ Relation _____

Glaucoma ☐ Relation _____

Other Eye Conditions ☐ What Kind? _____ Relation _____

Patients Signature _____