

# Welcome to Distinctive Eyewear Patient Information Form

\_\_\_\_\_  
Last Name First Name If minor, Parent's Name

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Home Phone Work Phone Cell Phone

\_\_\_\_\_  
Date of Birth Age Occupation

How did you hear about us? \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_ Reason for today's visit? \_\_\_\_\_

Do you have any history of eye problems? \_\_\_\_\_

Have you had any of the following?

**Eye Surgery Y / N**      **Eye Infections Y / N**      **Eye Injury Y / N**

Do **YOU** have any history of general health problems, such as:

**Diabetes Y / N**      **High Blood Pressure Y / N**      **Other \_\_\_\_\_**

Is there a family history of:

**Cataracts Y / N**      **Glaucoma Y / N**      **Diabetes Y / N**  
**Blindness Y / N**      **Macular Degeneration Y / N**      **High Blood Pressure Y / N**

Are you taking any medications? (please list) \_\_\_\_\_

Are you allergic to any medications? (please list) \_\_\_\_\_

As part of your eye exam, we may use drops to dilate your pupils. This will blur your vision for several hours and affect your ability to drive. May we dilate your eyes today? **Yes / No**

Do you have vision insurance? **Yes / No** Insurance ID#: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Name of person insurance is through: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Insured's relation to you: **Self / Spouse / Parent / Other** Insured's SS#: \_\_\_\_\_

***I authorize the release of any medical or other information necessary to process claims arising from services provided. I assume all financial responsibility for this account and all amounts due regardless of insurance coverage.***

***I have read and understand my rights under federal HIPPA laws.***

\_\_\_\_\_  
**Signature** **Date**

\_\_\_\_\_  
**Relationship (if signing for a minor)**