PROGRESSIVE
family eyecare

DATE: _____/_____/_____

Patient Information

Last name: _____ First name: _____ M or F

Name Preference: _____ DOB: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: (_____)_____-_____ Cell Ph: (_____)_____-_____ Work Ph: (_____)_____-_____

Email: _____ Communication Preference: Phone / Text / Email

Race: _____ Ethnicity _____ Preferred Language:_____

Employer and Occupation: _____

Date/Location of last eye exam: _____ Primary Care Physician: _____

Referral Source: _____

Vision Insurance: _____ ID#: _____

Primary Insurance Holder's Name: _____ DOB: _____ /_____/_____

Relationship to Patient: Self / Spouse / Parent

Medical Insurance: _____ ID#: _____

Primary Insurance Holder's Name: _____ DOB: _____ /_____/_____

Relationship to Patient: Self / Spouse / Parent

Do you currently wear glasses? Y or N Are you happy with your vision currently? Y or N

Do you wear contact lenses? Y or N or INTERESTED

IF you currently wear contact lenses, are you happy with the vision and comfort? Y or N

Do you use tobacco products? Y or N (If Yes: Type _____ Amount _____ How Long _____)

Do you drink alcohol? Y or N (If Yes: Type _____ __ Amount _____ How Long _____)

Please circle any of the following activities you engage in:

Golf	Music	Bicycle	Home Workshop	Bowling	Fishing	Swimming
Sewing	Ski	Hunting	Painting	Needlework	Flying	Photography

Other Hobbies or interests that have specific vision requirements? _____

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DATE: _____/_____/_____

Medical	Self	Medications – List Names	Relative – List Relationship
Diabetes			
High Blood Pressure			
Cholesterol			
Heart Disease			
Thyroid			
Arthritis			
Cancer (type)			
Asthma			
Behavioral/Psychiatric			
HIV/AIDS			
Herpes/Shingles			
Headaches/Seizures			
Allergies to Medication			
Other Not Listed			

Ocular	Self	Medications – List Names	Relative – List Relationship
Glaucoma			
Dry Eye			
Retinal Disease			
Macular Degeneration			
Eye Surgery			
Eye Injury			
Eye Allergies			
Blurred/Double Vision			
Other Not Listed			

I understand that I am responsible for any balance not paid by insurance.

Signed: _____ Date: _____/_____/_____