



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? \_\_\_\_\_



PROGRESSIVE  
family eyecare

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: \_\_\_\_/\_\_\_\_/\_\_\_\_