



Welcome and thank you for choosing Little Elm Eye Care for your vision needs. We are here to serve you, so please let us know if there is anything we can do to make your visit more enjoyable.

**Personal Information**

Name: Last, First, Middle \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Alt. # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

What are your hobbies? \_\_\_\_\_ E-mail Addr.: \_\_\_\_\_

Name of Parent/Spouse: \_\_\_\_\_ Any Children? What ages? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**Insurance Information**

Primary Insured Name: \_\_\_\_\_ Primary Insured Social Security #: \_\_\_\_\_

Primary Insured Date of Birth: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**Medical and Ocular History**

Review of Systems (Please circle which apply)	SELF	FAMILY	Please Explain.
Ear, Nose, Mouth or Throat problems?	Y N		_____
Cardiovascular disease (ex. High Blood Pressure, Heart disease)?	Y N		_____
Respiratory/Lung disease (ex. Asthma)?	Y N		_____
Gastrointestinal disease (ex. Acid reflux, Colon cancer)?	Y N		_____
Genitourinary disease (ex.. kidney problems)?	Y N		_____
Musculoskeletal problems (ex. Arthritis)?	Y N		_____
Skin disease (ex. Rosacea)?	Y N		_____
Neurological disease (ex.. MS)?	Y N		_____
Infectious disease (ie. HIV, Hepatitis, TB, etc.)?	Y N		_____
Psychiatric problems (ex. Depression)?	Y N		_____
Endocrine disease (ex. Thyroid disease, diabetes)?	Y N		_____
Blood Disorders (ex. Leukemia, Anemia)?	Y N		_____
Glaucoma	Y N	Y N	_____
Cataracts	Y N	Y N	_____
Blindness	Y N	Y N	_____
Retinal disease (ie. Macular degeneration, retinal detachment)	Y N	Y N	_____
Lazy eye, eye turns	Y N	Y N	_____
Color deficiency	Y N	Y N	_____
Any other eye problems	Y N	Y N	_____

Please list all medical problems that were not addressed above: \_\_\_\_\_

Please list all medications you are taking (incl. eye medications): \_\_\_\_\_

Please list all drug allergies and sensitivities: \_\_\_\_\_

Please list any past major illnesses or surgeries: \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ Where was it? \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ Contact Lenses? \_\_\_\_\_ If no, have you ever worn Contact Lenses? \_\_\_\_\_

Professional fees are due at the time of service. I understand that I am responsible for any balance unpaid by my insurance company.

\_\_\_\_\_  
Signature of Patient/Guardian