Welcome to our office!

Urban Eye MD Associates, P.C.

Please fill out as much information possible on both sides of this page.

Name: _____ **Date:**_____

Address: _____ **Apt#:**_____

City:_____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Gender: M___F___** **Marital Status:** _____

Social Security:_____ **Occupation:** _____

Phone numbers: Home: _____ **Cell:**_____ **Work:** _____

Email Address: _____ **(for appointment reminders)**

How did you hear about us?_____

INSURANCE AND EMERGENCY INFORMATION

Primary Medical Insurance:
Name of Carrier: _____ ID number: _____
Are you the subscriber? Y N If NO: Subscriber name: _____
Date of birth: _____Relationship: _____
Secondary Insurance Carrier: _____ ID number: _____

Vision Insurance:
Name of Carrier: _____ ID number: _____
Are you the subscriber? Y N If NO: Subscriber name: _____
Date of birth: _____Relationship: _____

IN CASE OF EMERGENCY CONTACT:_____
PHONE:_____RELATIONSHIP:_____

EYE HISTORY

Date of last eye exam: _____ **Where?**_____

Have you had your pupils dilated before? Y N
Do you wear glasses for distance Y N For near? Y N
Is your vision clear for distance? Y N For near? Y N
Do you wear contact lenses? Y N If not, are you interested in contact lenses? Y N
Are you interested in Laser Vision Correction? Y N
List any eye drops you are currently using: _____

Have you ever had and of the following?

Glaucoma Y N	Cataract Y N	Loss of vision Y N	Double vision Y N
Eye surgery Y N	Eye infection Y N	Eye injury Y N	Light sensitivity Y N
Floaters or spots Y N	Other (please list): _____		

SOCIAL HISTORY

Do you:
Play sports? Y N _____
Drive? Y N
Regularly use a computer? Y N How many hours per day? _____
Smoke? Never Ex-smoker YES: Number cigarettes per day? _____ How many years? _____
Drink alcohol? Y N If YES: How often? _____ How much? _____

MEDICAL HISTORY

Date of last physical exam: _____

Do you have any of the following conditions?

High blood pressure Y N Diabetes Y N Arthritis Y N Breathing problems Y N
Thyroid problem Y N Heart trouble Y N High Cholesterol Y N
List any other medical conditions: _____

List any medications you are taking: _____
_____
List any over the counter or herbal remedies you routinely use: _____
_____

Do you have any allergies to any medications? Y N
Please list: _____

Do you have any other allergies? Y N
Please list: _____

FAMILY HISTORY

Does anyone in your immediate family have any of the following conditions?

Glaucoma Y N Don't know IF YES, Who?_____
Blindness Y N Don't know IF YES, Who?_____
High blood pressure Y N Don't know IF YES, Who?_____
Diabetes Y N Don't know IF YES, Who?_____

Thank you for choosing Urban Eye M.D. Associates