The Eye Works Optometry
Welcome To Our Office

Patient Information	**Insurance Information**
Name_______________________M.I.___	Name of Vision Insurance:
Parent/guardian (minors)____________________	Primary Member Name:________________
Married: YES / NO	Primary's Birth Date: ________________
Street______________________________	Primary's SS#: ____________________
City ________________State_____Zip_______	
Phone (H)______________(W)____________	**How do you prefer to be contacted by us:**
Cell:________________	**PHONE EMAIL TEXT REGULAR MAIL**
E-Mail ____________________________	
Date of Birth ____________ Age___________	Last vision exam:__________________
Sex Male / Female	Major reason for today's visit: Circle any or all - Glasses Contacts Laser Correction Eye health Wellness Other
Name of Resp Party:_____________________	
Occupation:___________________________	Please explain: ____________________
School grade: ___________________________	Any problems/complaints related to current glasses or contacts?____________________

Very Important For New Patients!!!!!!

Who may we thank for referring you to our office? Name of friend or relative______________________

If not referred, how did you choose our office? Another doctor - Insurance list - Walk in/ Newspaper/ TV/ Radio/ Magazine - which one__________ Yellow Pages - which directory?__________

Internet: Google / Yelp / Yahoo / Other:______________________________

Personal - Lifestyle Questions

Do you…………….. Work at a computer? If yes, how many hours per day ________

Have an interest in contact lenses?__________

Have current prescription sunwear: Yes / No

Have children at home - Ages:____________

Spend time outdoors: Very Little / Moderate / A lot

Want info on Laser Vision Correction: Yes / No

Do you experience or have been diagnosed, or treated for any of the following:

☐ Chronic Dryness	☐ Sunlight Sensitivity
☐ Tearing/ Watery eyes	☐ Trouble at night
☐ Blurred Vision Far/Near	☐ Burning
☐ Cataracts	☐ Corneal abrasion
☐ Crossed/ Turned Eye	☐ Double Vision
☐ Eye infections	☐ Eye injury
☐ Flashes of light	☐ Floaters/ Spots
☐ Glaucoma	☐ Headache/Migraine
☐ Gritty, sandy, scratchy	☐ Iritis/Uveitis
☐ Itchy eyes	☐ Lazy Eye
☐ Macular degeneration	☐ Retinal Detachment
☐ Bothered by glare	☐ Eye surgery (explain) ______________________

Are there any specific tasks (hobbies) you currently perform where your glasses are not ideal?

Yes No N/A If yes please indicate what it is:

____

____

Patient Medical History **Patient Eye History**

Name of Family Physician___________________________
Date of Last Medical Exam ___________________________
Current Medications (**including eye drops, homeopathic, BCP**
____
____
____
____
____
Allergic to any eye drops or meds? If so, what? ___________
____

Have you been diagnosed or treated for any of the following?

- ☐ Allergies
- ☐ Arthritis
- ☐ Blood or Lymph Diseases
- ☐ Respiratory Diseases/Conditions
- ☐ Cholesterol elevated
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Skin conditions
- ☐ Herpes virus
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Neurological Disease/ conditions
- ☐ Psychological conditions
- ☐ Other
- ☐ Neck or back pain - chronic

Please explain:_______________________________________

Thank you,
Dr. Craig Sultan

Name of Last Eye Doctor____________________
Have you ever been told of any special concerns or conditions for you to be aware of: Yes No What:
____
____
____
____

Do you currently wear contacts? ________________
Satisfied with the vision and comfort from your contacts? ___________________________________
Issues/problems______________________________
If you do not currently wear contacts have you tried them in the past? __________ Reason for stopping
____
Ever been told you could not wear contacts ______
Why? _____________________________________

Family Eye History

Is there someone in your family with any of these:
Who?

- ☐ Blindness ________________________________
- ☐ Cataracts ________________________________
- ☐ Corneal Disease __________________________
- ☐ Diabetes _________________________________
- ☐ Glaucoma ________________________________
- ☐ Macular Degeneration ____________________
- ☐ Crossed or Wall eyed _____________________
- ☐ Retinal Disease ___________________________
- ☐ Lazy Eye _________________________________

Please review and sign the HIPPA and Financial Responsibility Forms
Remember to enter our Monthly Drawing for $150 Gift Certificate

If you are happy with the care and services you receive from us, please tell others.