# Welcome to Okemos Optometry

## Patient Information

Name: Last ___________________________________ First ____________________________ MI _________
Street Address: _______________________________________________________________________________
City: ______________________________________________ State: _________ Zip: _____________________
Phone: Cell ( ____ ) _________________ OK to Text __ Yes / __ No Home ( ____ ) ___________________
Email: _____________________________________________________________________________________
Social Security Number: _______________________________ Date of Birth: ______________________
Sex: __ Male __ Female Marital Status: __ Single __ Married __ Separated __ Divorced __ Widowed
Preferred Language: _________________ Race:________________ Ethnicity:________________________
Employer: _________________________________________ Occupation: _____________________________
Emergency Contact: _____________________________________________________________________
Phone: ( ____ ) _________________ Relationship: _______________________________________________

Insurance Information: *Please present ALL insurance cards*
Primary Vision Insurance Provider: ___________________________________ ID: _______________________
Member Name: _____________________________________________ Date of Birth: ____________________
Secondary Vision Insurance Provider: _________________________________ ID: _______________________
Member Name: _____________________________________________ Date of Birth: ____________________
Primary Medical Insurance Provider: __________________________________ ID: _______________________
Member Name: _____________________________________________ Date of Birth: ____________________
Secondary Medical Insurance Provider: ________________________________ ID: _______________________
Member Name: _____________________________________________ Date of Birth: ____________________

**Health History**
Eye History:
Last Eye Exam: _________________ Location of last eye exam: ____________________________________
Glasses: __ Yes / __ No Contacts: __ Yes / __ No Brand/Type: _____________________________________
Reason for today's visit:_____________________________________________________________________
____________________________________________________________________________________________
Have you or a family member experienced or been treated for any of the following visual issues:
__ Cataracts __ Cross Eye __ Glaucoma __ Lazy Eye __ Macular Degeneration __ Retinal Detachment
__ Lasik/PRK Other ___________________
Please Explain: _______________________________________________________________________________

Medical History:
Have you or a family member experienced or been treated for any of the following health issues:
__ AIDS/HIV __ Allergies __ Arthritis __ Asthma __ Blood/Lymph Disorder __ Cancer __ Diabetes
__ Heart Disease __ High/Low Blood Pressure __ High Cholesterol __ Lupus __ Neurological Conditions
__ Psychiatric Disorder __ Seizures __ Skin Conditions __ Thyroid Dysfunction Other _________________
Please Explain: _______________________________________________________________________________
____________________________________________________________________________________________
Current Medications (prescription and over-the-counter): ______________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Medication Allergies: __________________________________________________________________________
____________________________________________________________________________________________

Height:___________ Weight: ____________
Are you pregnant/nursing? __ Yes / __ No
Do you smoke? __ Yes / __ No Use other substances? __ Yes / __ No Drink alcohol? __ Yes / __ No
How did you hear about us? __________________________________________________________________