Welcome to Spearfish Eye Care Center

Date: _____ Social Security Number: _____

Patient's Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail address: _____

Phone: _____ Alternate Phone: _____

Marital Status: __ Married __ Single __ Divorced __ Widowed

Preferred method of contact: __ E-Mail __ Cell Phone __ Home Phone __ Mail Is texting okay? Yes or No

Place of Employment: _____ Occupation: _____

Race: __ Declined to Specify __ American Indian or Alaska Native __ Asian

__ Black or African American __ Native Hawaiian or Pacific Islander __ White

Ethnicity: __ Declined to Specify __ Hispanic or Latino __ Native Hawaiian or Pacific Islander

__ Not Hispanic or Latino

Insurance: _____ Policy # _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Social Security Number: _____ Date of Birth: _____

If you had your last exam here and purchased glasses here, please skip the next two questions.

1. How old are your present glasses? _____
2. Date of last eye exam: _____ If at another facility, Name of Eye Doctor _____

Date of Last Medical Exam: _____ **Primary Physician:** _____

Do you wear glasses? __ Yes __ No __ All the Time __ Sometimes __ Work Only __ Reading Only __ Driving Only

Do you wear contacts? __ Yes __ No __ All the time __ Sometimes: Wearing Schedule: __ Daily __ Overnight

Type/Brand of Contacts: _____ Solution Used: _____

Have you ever had any eye injuries? __ Yes __ No Describe: _____

Have you ever had any eye surgeries? __ Yes __ No Explain: _____

Do you use any eye medication? __ Yes __ No Explain: _____

Have you ever been diagnosed with any of the following: **(circle those that apply)**

Cataracts	Glaucoma	Dry Eyes
Macular Degeneration	Blindness or Loss of Vision	Eye Turn or Strabismus
Retinal Detachment	Lazy Eye or Amblyopia	

Any Additional Eye Problems? _____

What is your primary visual concern today? _____

Please list any activities you have difficulty doing because of your eyes or eyesight? _____

_____

Are you currently pregnant or nursing? __ Yes __ No

Whom may we thank for referring you to our office? _____

Signature: _____ Date: _____