Date:_____ **(please print)**

OPTIC GALLERY
Family Eye Care

PATIENT INFORMATION

Patient Name_____ Sex (M/F/non-binary) _____ DOB_____/_____/_____ Age _____

Address_____City_____State_____Zip_____

Nickname _____ Marital Status _____ Employment status _____

Primary Phone #_____(Home/work/cell) Employer/school_____

Alternate phone#_____(Home/work/cell) Occupation/grade_____

Social Security# _____-_____-_____ Email address:_____

INSURED INFORMATION

Insured's Name_____ Insured SSN_____ Insured DOB _____

Vision Insurance/ID # _____ Medical Insurance/ ID#_____

VISIT INFORMATION

Reason for today's visit _____

Last Eye Exam _____ Drs Name _____ Last Physical _____ Drs Name_____

List Activities & Hobbies _____

Does your work require any special vision needs? _____ Do you wear Sunglasses?_____

Do you wear contact lenses? Y / N Brand _____ If not, Interested in contacts?_____

How did you hear about our office? (include name if referred)_____

OCULAR HISTORY ⬚ I have No Ocular Symptoms Ocular Surgeries_____Date_____

(Check all that apply): (Specify eye)

⬚ Dryness ⬚ Watery Eyes ⬚ Retinal Detachment
⬚ Itchiness ⬚ Eye fatigue ⬚ Flashes and/or Floaters
⬚ Blurred Vision ⬚ Eye redness ⬚ Cataracts
⬚ Blindness (cause)_____ ⬚ Double Vision ⬚ Macular Degeneration
⬚ Eye Trauma (cause)_____ ⬚ Lazy Eye/crossed eyes ⬚ Glaucoma

MEDICAL HISTORY ⬚ I Have No Medical Conditions Recent Hospitalization (date/reason)_____

(Check all that apply):

⬚ Diabetes - Year Diagnosed:_____ A1c: ____ ⬚ Allergies ⬚ Sinusitis ⬚ Blood Disorder
⬚ Hypertension ⬚ Asthma ⬚ Kidney Disease ⬚ Cancer (type)_____ ⬚ Elevated Cholesterol ⬚ Headaches ⬚ Lung Disease ⬚ Thyroid Disease
⬚ Heart Disease ⬚ Autoimmune disease (type) _____

Medications _____

Are you pregnant/nursing?_____ Med Allergies _____ Social History: Smoke _____ Drink _____ Drugs _____

FAMILY OCULAR/MEDICAL HISTORY - ⬚ No Family History

(Please list your relation- i.e.-mother, maternal grandfather, brother, etc).

⬚ Blindness _____ ⬚ Diabetes_____ ⬚ Other _____
⬚ Macular Degeneration _____ ⬚ Hypertension _____
⬚ Glaucoma _____ ⬚ Cancer _____
⬚ Lazy eye/Crossed Eyes _____ ⬚ Heart/Lung Disease _____

I attest the above information is accurate and true regarding my personal information and personal/family history.

Optic Gallery Skye Canyon, LLC
9560 W Skye Canyon Park Dr. #180 Las Vegas, NV 89166
(702) 872-2020

Signature ____ **Witnessed by** ______________________________ **Date** _____________________