



focused on your vision

3551 Justin Rd, Suite 150 • Flower Mound, TX 75028

Patient Information Form

Thank you for choosing our office for your eye care needs. Please complete this form, and please ask for assistance if you have any questions.

Patient Information

Mr. Dr. Mrs. Ms. Miss Name: _____ Date: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (Work): _____

Phone (Mobile): _____ Driver's License #: _____

Email Address: _____ Social Sec. #: _____ - _____ - _____

Gender: Male Female Age: _____ Birth Date: ___/___/___ Occupation: _____

Reason for today's visit: _____

How did you first hear about Ogletree Eye Care? Phone Book Internet Drove By

Insurance Company List Another Patient --- Whom may we thank for referring you?

Medical Insurance: _____ **Vision Insurance:** _____

Primary Member's Information:

Name: _____ Birth Date: ___/___/___ Social Sec. #: _____ - _____ - _____

Eye Health History

Last Eye Exam: _____ Doctor: _____ Do you wear glasses? Yes No

Have you ever worn contacts? Yes No If yes, type of contacts: _____ Last worn: _____

Are you interested in wearing contacts? Yes No

Do you use a computer on a daily basis? Yes No If yes, how many hours per day? _____

Please check any of the following conditions you have now and/or have had in the past:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Redness | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Itchy, Watery Eyes | <input type="checkbox"/> Amblyopia (Lazy Eye) |
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Drooping Eyelid | | |

Please check if any of your blood relatives have now or had in the past any of the following conditions and their relationship to you:

- Blindness (Relationship: _____) Glaucoma (Relationship: _____)
- Retinal Detachment (Relationship: _____) Cataracts (Relationship: _____)
- Macular Degeneration (Relationship: _____)

(Please Turn Over)

Medical History

List any Medications you are taking: _____

List any Drug Allergies you have: _____

Females: Are you pregnant? Yes No Are you nursing? Yes No

Do you regularly use any of the following? Tobacco Alcohol Illegal Drugs

Please check any of the following conditions you have now and/or have had in the past:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Heart Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Discomfort | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Chronic Bronchitis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Breathing Difficulties |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Excess Fatigue | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Recurrent Infection | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Muscle Tenderness | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dry Throat/Mouth | <input type="checkbox"/> Emotional Difficulties | <input type="checkbox"/> Rosacea |

Please check if any of your blood relatives have or had any of the following conditions and their relationship to you:

- Cancer (Relationship: _____) High Blood Pressure (Relationship: _____)
 Diabetes (Relationship: _____) Heart Disease (Relationship: _____)

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and health care operations. Upon request, we can issue a copy of this policy.

By signing this form, you will consent to our use and disclosure of your protected health information to only carry out treatment, payment activities and submission of insurance.

Patient Signature: _____

If Patient is a Minor, Parent Signature: _____

Please visit our website at www.OgletreeEyeCare.com