LAKE NORMAN eye CARE & DRY EYE CENTER

Welcome to our office! It is our desire to provide you with the very best in vision care. We realize your time is valuable and our staff will try to attend to you as quickly as possible. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records. (PLEASE PRINT).

Date _____

PATIENT INFORMATION

Patient _____
Last name First name Initial Prefer to be called

Address _____

City _____ State _____ Zip _____

Gender □ M □ F □ Prefer not to answer Marital Status: Married Single Other

Race □ American Indian or Alaska Native □ Asian □ Black or African American □ Declined to Specify □ European □ Hispanic □ Native Hawaiian or Other Pacific Islander □ Other □ White

Date of Birth _____ Last 4 of SSN _____ Email Address _____

Home Phone _____ Work Phone_____ Cell Phone _____

Employer (or school) _____ Occupation (or grade) _____

Emergency Contact/Relationship_____ Phone _____

Family members who are patients _____

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

CANCELLATION FEES

☐ **Please initial to acknowledge that you have reviewed and understand our cancellation policy**

To ensure we can provide timely care to all patients, we require at least 24 hours' notice for appointment cancellations or rescheduling. Missed appointments or cancellations made with less than 24 hours' notice will be subject to a $50 no-show fee. We appreciate your understanding and cooperation in helping us keep appointments available for all patients in need of eye care services.

MEDICAL INSURANCE

Plan Name _____ Member ID _____ Group # _____

Primary Insurance Holder Name _____ Primary DOB _____ Primary Last 4 of SSN _____

Primary's Address _____ City_____ State_____ Zip_____

EYE HISTORY/ MEDICAL HISTORY

Additional medical data / medication information will be gathered in office during exam

Do you have dry eyes? ☐ Yes ☐ No

How many hours per day do you work on a computer? _____ Do you have any other specific visual demands? _____

Have you ever worn contact lenses? ☐ Yes ☐ No Are you interested in wearing contact lenses? ☐ Yes ☐ No

Do you have prescription sunglasses? ☐ Yes ☐ No Are you interested in refractive surgery (Lasik)? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

SOCIAL HISTORY

All responses are confidential and helps us provide safe, effective care.

Do you currently Drive: ☐ Yes ☐ No

Tobacco/ Nicotine Use: ☐ Yes ☐ No If yes, please specify type/frequency: _____

Alcohol Use: ☐ Yes ☐ No If yes, please specify type/frequency: _____

Current or past Recreational Drug Use: ☐ Yes ☐ No If yes, please specify type/frequency: _____

Have you been exposed to or infected with: ☐ HIV ☐ Hepatitis