GRIFFIN & REED EYE CARE

"Keeping your world in focus"

WELCOME TO OUR OFFICE

(Please Print)

Name_______________________________

Street_______________________________

City__________________State___Zip_______

Home Phone ____________________________

Wk Phone _______________Cell_____________

Date of Birth _____/_____/_____ Age_____ M / F

Single Married Divorced Drivers Lic# ______________

SSN:_______________________________

E-mail address ____________________________

Employer ____________________________

Parent's Name if not 18 ______________________

Emergency Contact ________________________

Relation____________Phone #______________

Vision Insurance Information

Insurance_______________________________

Subscriber Name_________________________

Subscriber SS# ID#_______________________

Subscriber Date of Birth _____/_____/_____

Are you Subscriber Spouse Dependant ☐ Partner

Primary Major Medical Insurance

Insurance_______________________________

ID#___________________Group#_________

Subscriber Name_________________________

Subscriber Date of Birth _____/_____/_____

Are you Subscriber Spouse Dependant ☐ Partner

Secondary Major Medical Insurance

Insurance_______________________________

ID#_______________Group# ____________

Subscriber Name_________________________

Subscriber Date of Birth _____/_____/_____

Are you Subscriber Spouse Dependant ☐

Please Update Your Medical History

(please circle if you have ever had the following)

Allergies: Seasonal Allergies Contact Lens Solution Eye Drop Allergies

Allergies to Medications: Y / N

List_______________________________________

Primary Care Physician:___________________

Current Medications:______________________

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Respiratory Problems: Shortness of Breath Wheezing Coughing Asthma Emphysema

Heart: Chest Pain Angina Irreg or Fast Heart Beat High Cholesterol

Blood: High Blood Pressure HIV Aids

Nervous System: Hearing Problems Migraine Headaches Dizziness Stroke Paralysis Alzheimer

Endocrine: Diabetes Thyroid Problem

EYE HISTORY

FOR YOU OR ANY BLOOD RELATIVES

S=Self. M=Mother, F=Father, B=Brother ,S=Sister

- Cataract S M F B S ____________
- Glaucoma S M F B S ____________
- Lazy/Crossed eyes S M F B S ____________
- Diabetes S M F B S ____________
- Night Blindness S M F B S ____________
- Retinal or macular Degeneration S M F B S ____________

List Any Eye Surgeries____________________

Contact Lenses

Have you ever worn Contact Lenses? Yes No

Do you wear them now? Yes No

Hobbies or Sports you participate in..

Aerobics	Computers	Mt Climbing	Tennis
Baseball	Dancing	Music	Track
Basketball	Fishing	Reading	VllyBll
Bicycling	Football	Scuba/Snrkl	Wtr Spts
Boating	Gardening	Skiing	Writing
Bowling	Golf	Soccer	
Camping	Hunting	Swim	

How did you hear of our office?

Internet Friend or Family member

Radio Station ___________ Other____________