englewood
EYECARE
850 Englewood Parkway, Suite 100A
Englewood, CO 80110

Today's date: ____/____/____
Last name: _____First name: _____M.I:_____
Address: _____City:_____State:_____ ___Zip:_____
Home phone: (_____) _____ _Work phone: (_____) _____SSN:_____-_____-_____
Date of birth: ____/____/____Occupation:_____ Employer: _____
School (if student):_____ Grade:_____ Name of parent/spouse:_____
Referred by: _____Is this exam for glasses/contact lenses/LASIK?(Circle all that apply)
Other: _____Date of last exam: _____
Email address: _____

MEDICAL INFORMATION

General health: _____
Do you have any problems with the following? (Circle Yes or No):

Gastrointestinal	Yes/No	Nervous	Yes/No	Blood	Yes/No
Ears/nose/throat	Yes/No	Urinary	Yes/No	Allergies	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Headaches	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Mental	Yes/No
High blood pressure	Yes/No	Glands	Yes/No	Diabetes	Yes/No

Please explain: _____
Allergies: _____Allergies to medications: _____
Current medications: _____Check if none: (____) ;Family doctor:_____

PERSONAL EYE HISTORY:

Have you had any eye injuries? Infections? Surgeries? Please explain: _____
Allergies that affect your eyes?_____ Excessive tearing ? Redness? Itching?_____
Macular degeneration? Cataracts? Glaucoma? Dry eyes? Retinal detachment? Blurred or double vision?
(Circle all that apply). Do you currently wear glasses? Yes/No. How old are your glasses? _____
Do you currently wear/used to wear contact lenses? (Circle, if applicable) If so, what brand? _____

FAMILY HISTORY:

High blood pressure? No/Yes, Relation:_____Glaucoma? No/Yes, Relation:_____
Diabetes? No/Yes, Relation: _____Macular degeneration? No/Yes, Relation: _____
Cataracts? No/Yes, Relation: _____ Retinal detachment? No/Yes, Relation: _____

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

Insurance: (Name of company) _____ (___) Check if none; Policy holder:_____
Policy holder's SSN: ____/___/____ Insurance ID#_____ Group #_____

To our patients: We are happy to assist in the preparation of your vision insurance forms. However, you are ultimately responsible for payment of your bill if your insurance company does not.

I have read the above paragraph and understand it completely.

Signed: _____ Date:_____/_____/_____