Patient Information Form

Eyes on Burbank Optometry
2005 W. Alameda Ave., Burbank, CA 91506
Phone: 818-476-4606

Patient Information

Full Name: _____ **Date of Birth**:_____

Gender: ☐ Male ☐ Female ☐ Other

Address: _____**City**: _____ **State**: _____ **ZIP**: _____

Phone Number: (____) - _____ **Email**: _____

Emergency Contact

Name: _____**Relationship to Patient**: _____**Phone Number**: (____) - _____

Insurance Information

Primary Insurance Provider: _____**Policy Number**: _____

Group Number (if applicable): _____**Subscriber's Name**: _____

Relationship to Patient: _____

Secondary Insurance Provider _____**Policy Number**: _____

Primary Care Physician Information

Physician's Name: _____**Physician's Phone Number**: (____) -_____

Referring Doctor (if applicable): _____

Primary Reason for Today's Visit:

_____

_____

Vision and Medical History

Do you currently wear glasses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, what brand/type? _____

Have you ever had any eye injuries or surgeries? ☐ Yes ☐ No If yes, please describe: _____

Do you have any of the following ocular conditions?

☐ Blurry Vision

☐ Dry Eyes

☐ Eye Pain

☐ Double Vision

☐ Headaches

☐ Light Sensitivity

☐ Glaucoma

☐ Macular Degeneration

☐ Lazy/Crossed Eye(s)

☐ Floaters and/or Flashes of Light

☐ History of a Retinal Detachment

☐ Other: _____

Have you ever had any eye surgeries/procedures? ☐ ☐Yes ☐ No

If Yes, please specify type:_____

Date of surgery:_____

Do you have any of the following medical conditions?

☐ Diabetes

☐ Hypertension

☐ Heart Disease

☐ High Cholesterol

☐ Thyroid Problems

☐ Cancer

☐ Arthritis

☐ Asthma

☐ Other: _____

☐ Ocular Conditions: _____

Do you have any family history of the following:

☐ Glaucoma

☐ Macular Degeneration

☐ Blindness

Do you have any allergies to any medication? ☐ Yes ☐ No If yes, please specify: _____

What medications do you currently take?

_____

_____

Do you smoke or use tobacco products? ☐ **Yes** ☐ **No** If yes, how often? _____

Do you consume alcohol? ☐ **Yes** ☐ **No** If yes, how often? _____

Authorization and Signature

I verify that the information provided is accurate to the best of my knowledge. I authorize *Eyes on Burbank Optometry* to contact me regarding appointments, medical information, and billing. I understand that I am responsible for notifying *Eyes on Burbank Optometry* of any changes to my contact or insurance information.

Signature of Patient or Legal Guardian: _____
Date: _____