

**NEW PATIENT INFORMATION**

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YOUR APPOINTMENT TO SEE THE DOCTOR IS SCHEDULED FOR \_\_\_\_\_  
IN ORDER TO SERVE YOU MORE EFFICIENTLY, PLEASE FILL OUT THIS FORM BEFORE  
YOUR APPOINTMENT AND BRING IT WITH YOU TO OUR OFFICE. \*\*\*PLEASE PRINT\*\*\*

PATIENT NAME \_\_\_\_\_ (M)(F) HOME PHONE \_\_\_\_\_  
NAME OF SPOUSE OR PARENT \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
E-MAIL \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
SOCIAL SECURITY NO \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_ POSITION \_\_\_\_\_  
NAME OF REGULAR PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_  
NAME OF PREVIOUS EYE DCOTOR: \_\_\_\_\_

**IN CASE OF EMERGENCY CALL** \_\_\_\_\_  
WHAT EYE PROBLEMS ARE YOU CURRENTLY EXPERIENCING? \_\_\_\_\_

WHAT EYE PROBLEMS HAVE YOU EXPERIENCED IN THE PAST? \_\_\_\_\_

HAS ANYONE IN YOU FAMILY HAD: CATARACTS?: Y/N GLAUCOMA?: Y/N  
CROSSED EYES?: Y/N OTHER?: \_\_\_\_\_

DURING THE PAST YEAR, HAVE YOU BEEN UNDER THE CARE OF PHYSICIAN? \_\_\_\_\_  
IF YES, LIST REASONS WHY \_\_\_\_\_

DO YOU HAVE A HISTORY OF PROBLEMS WITH:  
HIGH BLOOD PRESSURE?: Y/N DIABETES?: Y/N HEART?: Y/N  
ANY OTHER HEALTH PROBLEMS? \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS, PILLS AND/OR EYE DROPS YOU ARE PRESENTLY TAKING:  
\_\_\_\_\_

ARE YOU ALLERGIC TO: PENICILLIN? \_\_\_ASPIRIN? \_\_\_CODEINE? \_\_\_OTHER? \_\_\_

WHEN WAS THE LAST TIME YOU GOT A NEW PRESCRIPTION FOR YOUR GLASSES? \_\_\_\_\_

- PLEASE BRING THE FOLLOWING WITH YOU TO EACH APPOINTMENT:**
1. THE GLASSES YOU USUALLY WEAR AND/OR CONTACT LENSES.
  2. ALL MEDICATIONS AND DROPS YOU USE FOR YOUR EYES.
  3. IF YOU WEAR HARD OR SOFT LENSES PLEASE WEAR THEM AS YOU NORMALLY WOULD.

\*\*\*IF YOU NEED TO RESCHEDULE OR CANCEL FOR ANY REASON, WE WOULD APPRECIATE YOU CALLING OUR OFFICE AT LEAST 48 HOURS PRIOR TO YOUR SCHEDULED TIME\*\*\*

**CONSENT TO TREAT AND ASSIGNMENT OF BENEFITS**

I GIVE MY CONSENT TO BE TREATED BY DAVIDORF EYE GROUP.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_