Up North Eye Care
Patient Information Form

This is a two-sided form

GENERAL INFORMATION

First, Last, MI, Preferred Name _____

Street Address _____

City, State, Zip _____

Phone, Type _____

Phone 2, Type _____

Date of Birth _____ Male/Female *(please circle)*

Occupation/Employer _____ *full-time / part-time*

Marital Status *married / single / divorced / legally sparated / widowed*

Emergency Contact Person and Phone _____

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name _____

Vision Insurance Member ID# _____

Vision Insurance Member Date of Birth _____

Primary Medical Insurance

Primary Member Name _____

Insurance ID# _____

Insurance Member Date of Birth _____

Primary Member Employer _____

Your Relationship to Primary Member *spouse / child / other (please exaplain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name _____

Secondary Medical Insurance ID# _____

Secondary Medical Insurance Policy #/Group ID# _____

Secondary Medical Insurance Member Date of Birth _____

Your Relationship to Secondary Medical Insurance Member *spouse / child / other*

please turn over

EYE HISTORY

Date of Last Eye Exam _____

Currently Wear Glasses? _____

Currently Wear Contacts? _____

Reason for Today's Visit _____

_____

_____

_____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	yes	no	family
Lazy Eye	yes	no	family
Glaucoma	yes	no	family
LASIK or RK	yes	no	
Retinal Detachment	yes	no	family
Macular Degeneration	yes	no	family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ○ Blurry Vision n*ear or distance*
- ○ Burning
- ○ Discharge
- ○ Double Vision
- ○ Dryness
- ○ Excess Tearing/Watering
- ○ Eye Infection
- ○ Eye Pain or Soreness
- ○ Floaters or Spots
- ○ Halos
- ○ Headaches
- ○ Redness
- ○ Light Sensitivity
- ○ Light Flashes
- ○ Itching
- ○ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been Treated for, any of the following? Circle all that apply

AIDS/HIV	yes	no	family
Allergies	yes	no	family
Arthritis	yes	no	family
Asthma	yes	no	family
Blood/Lymph Disorder	yes	no	family
Cancer	yes	no	family
Diabetes	yes	no	family
Ears, Nose, Throat Conditions	yes	no	family
Gastrointestinal Conditions	yes	no	family
Heart Disease	yes	no	family
High Blood Pressure	yes	no	family
High Cholesterol	yes	no	family
Kidney Disease	yes	no	family
Lupus	yes	no	family
Neurological Conditions	yes	no	family
Psychiatric Disorder	yes	no	family
Seizures	yes	no	family
Skin Conditions	yes	no	family
Stroke	yes	no	family
Thyroid Dysfunction	yes	no	family

Medication Allergies

_____

_____

_____