A. Kevin Young Eye Care Center
1220 E. Robinson
Norman, OK 73071
405-360-3590

WELCOME TO OUR OFFICE

Date _____ Social Security _____

Patient's Name _____ Date of Birth _____
LAST FIRST MIDDLE

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Position _____ Phone _____

Spouse's Employer _____ Position _____ Phone _____

Emergency – Who to notify _____ Phone _____

Whom may we thank for referring you to this office? Name: _____

_____ Family _____ Friend _____ Phone Book _____ Other, explain _____

Other Family Members, Still Living at Home:

Spouse _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Please check the method of payment for today's professional services:

_____ Cash _____ Check _____ Credit/Debit Card

I understand that payment is required at the time services are rendered.

_____ _____
SIGNATURE OF PARTY RESPONSIBLE FOR PAYMENT RELATIONSHIP

INSURANCE INFORMATION:

Insurance Name: _____

Member Name: _____

Member DOB _____

Member SS # _____

OVER

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PATIENT INFORMATION FORM

Patient's Name _____

First Visit? Yes _____ No _____ Date of last Eye Health Exam _____

What problem are you having with your eyes? _____

Related problems? (headaches, sinus, etc.) _____

Are you sensitive to light? Yes _____ No _____ Fluorescent Lights _____ Glare _____ Snow _____ Sun _____

Do you work with a computer? Yes _____ No _____

Have you ever or do you now wear contact lenses? If so, what type? _____

If not, have you ever thought about wearing contacts? Yes _____ No _____

General Health (Past or Present) Good _____ Fair _____ Poor _____

Date of last tetanus shot? _____

Name of Family Physician _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substances _____

Do you have any of the following conditions?

Allergies _____ High Blood Pressure _____ Glaucoma _____ Floaters _____

Diabetes _____ Drug Sensitivities _____ Headaches _____ Flashing Lights _____

Eye Surgery _____ Eye Disease _____ Cardiovascular _____ Respiratory _____

Other _____

Is there anyone in your family that has:

Glaucoma Yes _____ No _____

Diabetes Yes _____ No _____

Other eye health problems Yes _____ No _____

Explain _____

_____

What medications are you presently taking? _____

_____

What sports and hobbies do you enjoy? _____

_____

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