

Golden Triangle Optometric Center
Lori J. Bende, OD, Professional Optometric Corporation

PATIENT INFORMATION

Name (Mr./Mrs./Ms./Dr.) _____ Birthdate _____
Address _____ City _____ State _____
Zip Code _____ Home phone _____ Work phone _____
Cell Phone _____ SS # _____
Marital Status ___ Employer _____ Occupation _____
Children & Ages _____ E-Mail Address _____
Date of last eye exam _____ Age of present glasses _____
How referred to our office _____

INSURANCE INFORMATION

Vision Insurance (*please circle*): VSP MESC AVP Medicare Medi-CAL
Other Insurance _____ Flexible Spending Account: (*circle*) Yes No
Insured Name _____ Policy # _____ Group

If VSP (*please circle*): Standard VDT Second Pair Primary Eyecare Laser Other

HEALTH HISTORY

List all allergies _____
List medication allergies _____
List all Medications _____
General Health Condition _____ Are you pregnant? _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substances? _____
Hobbies/Sports _____
Do you wear contact lenses? _____ What Type? _____
Are you interested in new contact lenses? _____
Are you interested in Refractive Surgery (LASIK) yes _____ no _____

Have you ever had (*please check all that apply*):

blurred vision severe or frequent headaches itchy/red/tearing eyes
floaters/flashes eye disease, injury or surgery double vision
eyestrain or pain other _____

Do you or any blood relatives have (*please check and specify who*):

glaucoma _____ eye diseases _____
blindness _____ thyroid problems _____
diabetes _____ high blood pressure _____
asthma _____ heart disease _____
cataracts _____ other health problems _____

Primary Care Physician _____
Emergency Contact _____ Relationship _____
Address _____ City _____
State _____ Zip _____ Phone _____
Best place/time to notify you: home ___ work ___ time of day _____

_____ Date Completed _____

(Please sign)