Somerville Family Eyecare, LLC

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Somerville, NJ 08876
Phone (908) 725-0144
www.somervillefamilyeyecare.com

Name _____ Single Married Divorced Widowed

Address _____ Home Phone # _____

City , State, Zip Code _____ Work Phone # _____

Date Of Birth _____ Age _____ Social Security # _____ Cell Phone # _____

Legal Guardian (if under age 18) _____ Occupation / Employer _____

Do you have medical insurance? Yes No _____
Medical Insurance Company Name

Do you have routine vision insurance? Yes No _____
Routine Vision Insurance Company Name (if different from medical insurance)

Whom may we thank for referring you to our office? _____

Your email address for Patient Portal access: _____

Ocular History

When was your last eye exam? _____ Do you work on a computer more than 2 hours a day? Yes No

Does your work have any unusual visual requirements? Yes No Explain: _____

Do you currently wear glasses? Yes No Type: _____ How old are they? _____

Please circle what type of contact lenses you wear, if any? How old are they? _____

Disposable Bifocal Astigmatism Gas Permeable Extended Wear Soft

Are you interested in learning more about Laser Vision Correction? Yes No

CONTINUED ON BACK

Please circle any of the following that apply to you:

Eyestrain	Headaches	Blurred Vision	Floating Spots	Flashing Lights	Double Vision	Dry Eye	Vision Loss	Light Sensitivity
Itching	Eye Injury	Eye Surgery	Glaucoma	Cataracts	Retinal Disease	Amblyopia (lazy eye)	Corneal Disease	Macular Degeneration

Medical History

Who is your primary care physician? _____ Date of last physical exam? _____

What medications are you presently taking? _____

List any medications you may be allergic to: _____

Please circle any of the following health conditions that apply to you:

Diabetes	Arthritis	Thyroid Disease	Heart Disease	High Blood Pressure	High Cholesterol	Lung Disease	Allergies	Gastrointestinal
Sarcoidosis	HIV	Lupus	Skin Disease	Mitral Valve Prolapse	Liver Disease	Seizures	Kidney Disease	Osteoporosis
Lyme Disease	Sinusitis	Hematologic	Shingles / Herpes	Myasthenia Gravis	Cancer			

List any other health conditions: _____

Family History

Please circle any of the following that apply to your blood relatives:

Glaucoma	Cataracts	Retinal Disease	Amblyopia (lazy eye)	Corneal Disease	Macular Degeneration

Please circle any of the following health conditions that apply to your blood relatives:

Diabetes	Cancer	High Blood Pressure	Thyroid Disease	Heart Disease	Gastrointestinal

Payment Policy

Payment is due in full at the time services are rendered. We accept cash, check, Visa, MasterCard, or Discover. Please be advised that all past due balances are subject to interest and collection / attorney fees.

_____ _____

Patient or Guardian's Signature Date