Ferman Optometry New Patient Form

Who may we thank for referring you? _____

Patient Information Please complete this entire section

First Name Middle (optional) Last Name Preferred Name/Nickname

Date of Birth Last 4 digits of patient SS# CIRCLE ONE: Male Female

Street Address City, State, ZIP

Primary Phone # Patient email (optional; we DO NOT share this with anyone)

CIRCLE ONE: mobile home work

Your preferred method of contact - CIRCLE ONE: call text email

Emergency Contact First & Last Name

Emergency Contact Phone # Relation to patient

CIRCLE ONE: mobile home work

Parent/Guardian Information Please complete this if patient is a dependent

First Name Middle (optional) Last Name Preferred Name/Nickname

Date of Birth Last 4 digits of parent SS# CIRCLE ONE: Male Female

Street Address City, State, ZIP

Primary Phone # Parent email (we DO NOT share this with anyone)

CIRCLE ONE: mobile home work

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Insurance Information

Primary Policy Holder (Member) CIRCLE ONE: Is the policy… *vision or medical* insurance?

Relationship to primary member… *self child spouse other (please explain)* _____

Member Name **as it appears on insurance policy** | Member Date of Birth | Last 4 digits of member SS#

Insurance Company | Member ID or policy # | Group # | Plan name (*if applicable*)

Secondary Policy Holder (Member) CIRCLE ONE: Is the policy… *vision or medical* insurance?

Patient relationship to secondary member… *self child spouse other* (*please explain*) _____

Member Name **as it appears on insurance policy** | Member Date of Birth | Last 4 digits of member SS#

Insurance Company | Member ID or policy #

Medical History Please complete this entire section

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

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

Current Medications & dosage. Include both prescription and over-the-counter meds.

List any drug allergies here:

Have you ever smoked?	*yes no*	Are you pregnant or nursing?	*yes no*
Do you currently smoke?	*yes no*		

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Vision History Please complete this entire page

Date of last eye exam:	
Do you wear prescription eyeglasses?	*yes no*
Wearing eyeglasses how long?	
Have you ever worn bifocal lenses?	*yes no*
Have you ever worn progressive lenses?	*yes no*
Do you wear prescription sunglasses?	*yes no*
Do you wear computer glasses?	*yes no*
Do you wear reading glasses? (readers)	*yes no*
Do you wear safety glasses?	*yes no*
Do you wear sports goggles?	*yes no*

Currently wear contact lenses?	*yes no*
Wearing CLs how long?	
What brand of CL?	
What type of CL?	*daily weekly monthly*
What solution(s) do you use?	

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

Cataracts	*yes no family*
Crossed Eye	*yes no family*
Glaucoma	*yes no family*
LASIK or RK	*yes no family*
Amblyopia (Lazy Eye)	*yes no family*
Macular Degeneration	*yes no family*
Retinal Detachment	*yes no family*
Strabismus (Eye turn)	*yes no family*

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

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

Are you experiencing any difficulty with the following?

Reading small print	*yes no*
Reading text on a mobile device	*yes no*
Reading a newspaper or book	*yes no*
Working on the computer	*yes no*
Recognizing people up close	*yes no*
Seeing steps, stairs, or curbs	*yes no*
Difficulty driving on sunny days	*yes no*
Difficulty driving at night	*yes no*
Reading street or traffic signs	*yes no*
Doing fine handiwork	*yes no*
Writing checks	*yes no*
Playing games(*eg* cards, bingo)	*yes no*
Participting in sports	*yes no*
Cooking/Hobbies	*yes no*
Watching TV	*yes no*

Please sign and date

patient signature date