Welcome to Infinity Eye Care

Today's Date ______________________________

Patient Information

Last ______________________________
First ______________________ MI ________
Nickname ______________________________
Street ______________________________
City ______________ State______ Zip________
Home Phone ______________________________
Work Phone ______________________________
Cell Phone ______________________________
Email Address ______________________________
Patient's SSN ______________________________
Date of Birth ______________________________
Sex ❑M ❑F
Employer (or School) ______________________
Occupation (or Grade)______________________
Spouse (or Parent's Name) __________________
Spouse (or Parent's Work) __________________
Were you referred to our office? ❑ Yes ❑ No
Referred By? ______________________________
What is the major purpose of this visit?

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Insurance Information

Vision Insurance______________________________
Subscriber Name______________________________
Subscriber SSN______________________________
Subscriber Birth Date______________________________
Subscriber Address ______________________________
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Primary Medical Insurance______________________
Subscriber Name______________________________
Subscriber SSN______________________________
Subscriber Birth Date______________________________
Subscriber Address ______________________________
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Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company and not Infinity Eye Care.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to Infinity Eye Care.

X ______________________________________
Patient Signature

Patient Eye Conditions

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Double Vision
- ❑ Flashes of light
- ❑ Sunlight Sensitivity
- ❑ Trouble seeing at night
- ❑ Floaters
- ❑ Headaches
- ❑ Itchiness
- ❑ Spots
- ❑ Dryness
- ❑ Tearing
- ❑ Redness
- ❑ Other eye disorders
- ❑ Cataracts
- ❑ Retinal Detachment
- ❑ Glaucoma
- ❑ Glaucoma Suspect
- ❑ Macular Degeneration
- ❑ Keratoconus
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Eye Turn
- ❑ Eye Allergies
- ❑ Eye Injury
- ❑ Eye Surgery

Patient Medical History

Have you had any surgeries? ❑ Yes ❑ No

Please check if you use any of the following substances:
❑ Tobacco ❑ Alcohol ❑ Other

Are you currently pregnant or nursing? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Thyroid	❑	❑

Other:

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