Michael P. Anastasio, OD Katherine E. Anderson, OD Robert W. Banglmaier, OD Kyle S. Benner, OD
Amy B. Cyr, OD Steven A. Goldstein, OD Timothy A. Kearins, OD Sian E. Liem, OD Katherine D. Nickerson, OD

## Welcome!

**The information you provide below is part of your medical record, and will be held in strict confidence. PLEASE PRINT.**

**Patient Information**

*Circle* if desired: Mr. Mrs. Ms. Miss Mx. Dr. Your pronouns: She/Her He/Him They/Them None Other ______

Legal last name______________________________ Legal first name____________________________ MI __________

Preferred name_____________________________________________________ Date of birth______________________

Sex at birth: M F Intersex Current gender: M F Non Binary Trans Other ____________________________

Mailing address____________________________________________________________________________________

City_________________________________________________State_______________ZIP Code _____________________

Telephones: Primary________________________________Secondary______________________________________

Employer_________________________________________Occupation ___________________________________________

E-mail ____________________________________________________ Social Security number _____________________

Is this your first visit with us? Yes No If yes, who referred you? __________________________________________

Emergency contact___________________________________________Telephone _______________________________

Race:

- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Decline to answer

Ethnicity:

- ☐ Latino/Hispanic
- ☐ Unknown
- ☐ Not Hispanic or Latino
- ☐ Decline to answer

What is the primary language spoken at home? ________________________________________

Are you hard of hearing? Yes No Are you deaf? Yes No

**Responsible Party (*If other than the patient, please complete the following.)***

Circle one: Mr. Mrs. Ms. Miss Mx. Dr.

Last name______________________________Suffix________First name____________________________MI ________

What is the patient's relationship to the responsible party? __________________________________________________

Date of birth_________________ Social Security number ___________________________________________________

Mailing address____________________________________________________________________________________

City_________________________________________________State_______________ZIP Code _____________________

Telephones: Home____________________Work_________________________Mobile____________________________

*Professional fees for all services are payable at the time services are rendered. Fifty percent of fees for contact lenses and eyeglasses are payable when they are ordered, with the balance due when they are dispensed.*

**Please sign below that you have completed the above information to the best of your knowledge.**

Signature ____________________________________________________________ Date ___________________________

**Patient or Parent/Guardian**

**Please Continue on the Other Side.**

# Patient History

**Personal Ocular History: Are you being monitored for any of the following ocular conditions?**

☐ Macular Degeneration ☐ Keratoconus ☐ Glaucoma

☐ Other: ______________________________

☐ History of eye surgeries: ______________________________
Procedure(s) and date(s)

**Please list the medications that you currently take**. Attach a list if you need more space:

______________________________

______________________________

______________________________

______________________________

Are you allergic to any medications? ______________________________

Other Allergies? ______________________________

When was your last physical? __________ Who is your primary care physician? ______________

When was your last eye exam? __________ Who was your last eye doctor? ______________

Do you use tobacco? **Yes No** If yes, type and amount? ______________________________

Recreational drug use? **Yes No** If yes, type and amount? ______________________________

Do you drink alcohol? **Yes No** If yes, type and amount? ______________________________

**Family Medical History: Please check any condition that applies to your immediate family:**

☐ Glaucoma If yes, relation? ______________________________

☐ Macular Degeneration If yes, relation? ______________________________