3Visions Ophthalmology

First Name: _____**MI**:_____ **Date of Birth** ____/_____/_____

Last Name: _____**SS#**_____

Legal Sex: (circle one) **Male Female**
Gender Identity: (circle one) **Male/ Female /Transgender / Male or Female /Genderqueer /Declined /Other**

Home Address _____Apt#_____
City _____State_____Zip_____

Home Tel#_____ **Cell#**_____

Email Address: _____

Referring Physician: _____

Pharmacy Name:_____.

Tel#:_____.

Race/Ethnicity: __Caucasian ___ Black ___Hispanic __Asian __Other

__Native American __Asian Pacific American ___More than one race

Insurance Company _____ID#_____

Insured/Card Holder Name:_____

Relationship: _____ Phone #_____

Type of Insurance (circle): Commercial Medicaid Medicare Other _____

Emergency contact Name: _____Last_____Relationship_____

Tel Home#_____Cell#_____Work#_____

Have you ever had the following?

Diabetes……..	Yes	No
Hypertension……...	Yes	No
Cancer…….….	Yes	No
Stroke……..	Yes	no
Heart trouble……...	Yes	no
Arthritis/gout……...	Yes	no
Convulsions…….	Yes	no
Bleeding tendency……	Yes	no
Acute infections……	Yes	no
Venereal disease……	Yes	no
Hereditary defects…….	Yes	no
Glaucoma……...	Yes	no
Cataract…….	Yes	no

Patient Vitals: Height_____ Weight _____ Age _____

Occupations: _____

Allergies: _____

Patient Social History

Marital Status:___Single___Married___Separated___Divorced___Widowed

Use of alcohol: ___Never___Rarely___Moderate___Daily

Use of tobacco: ___Never___Previously but quit___Current packs/day_____

Use of Drugs: ___Never___Type/Frequency_____

Excessive exposure at home or work to:___Fumes___Dust___Solvents ___Noise

List medications you are currently taking (use back page if need more room):

_____

_____

_____

_____

_____

_____

Patient Signature_____Date_____