Harrel eyecare.

WELCOME

Thank you for choosing our office for your eyecare needs! We're glad to help if you have questions.

All Patient Information is Confidential

Mr. Mrs. Ms. Dr. Name: ____________________ Date: __________

Address: ____________________ City/State: __________ Zip: __________

Cell Phone: __________ Home Phone: __________ Text OK?: __________

Email: ____________________ Birthdate: __________

Patient's SSN: ____________________ Occupation: __________

Height: ____________________ Weight: __________

❒ Male ❒ Female

Marital Status: ❒ Single ❒ Married

Preferred Method of Communication: ❒ Text ❒ Email ❒ Cell Phone ❒ Home Phone

Preferred Language: ❒ English ❒ Spanish ❒ Other: __________

Race: (optional)
- ❒ American Indian or Alaskan Native
- ❒ Black or African American
- ❒ Native Hawaiian or Pacific Islander
- ❒ Asian
- ❒ Hispanic
- ❒ White

Primary Physician/Pediatrician: ____________________

Preferred Pharmacy: ____________________

Insurance Information

If you are using insurance, we need to copy your medical and vision cards if you have one. We provide treatment for both medical eye conditions as well as comprehensive vision care. Thank you.

Primary Member's Name: ____________________ Primary Member's Employer: __________

Primary's social security #: ____________________ Primary Member's Birthdate: __________

Please Fill Out Both Sides

Your Eye Health and Vision are important to us.

Health History

Please indicate if you or your family (blood relatives only) have any of the following:

Condition	Patient	Family	Condition	Patient	Family
Diabetes	❒	❒	Glaucoma	❒	❒
High Blood Pressure	❒	❒	Cataracts	❒	❒
High Cholesterol	❒	❒	Turned Eye	❒	❒
Heart Disease	❒	❒	Lazy Eye	❒	❒
Kidney Disease	❒	❒	Eye Injury	❒	❒
Thyroid Disease	❒	❒	Eye Surgery	❒	❒
Asthma	❒	❒	Blindness	❒	❒
Cancer	❒	❒	Macular Degeneration	❒	❒

Other Systemic Conditions: ______________________________

Please indicate if any of the following apply to you:

❒ Allergies ❒ Smoker

❒ Pregnant ❒ Frequent Headaches

Medications you are currently taking OR we can copy a list if you have one: ❒ None

____

Please list medications you allergic to:

____