CLARITY EYECARE

☐ Ms ☐ Mr ☐ Mrs ☐ Dr Name: First Last

Address: Street DOB

SSN (last 4)

City State Zip

Phone: Home Cell Work

Email: Gender (for ins verification) ☐ F ☐ M

Insurance: Vision: Medical:

Primary account holder: Name: First Last

Address: Street DOB

SSN (last 4)

City State Zip

Phone: Home Cell Work

Email: Gender (for ins verification) ☐ F ☐ M

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Medication: List

☐ None

Medication allergies: List

☐ None

Personal ocular history:

- ☐ Laser vision correction
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Retinal hole/tear/detachment
- ☐ Amblyopia (Lazy eye)/Strabismus (eye turn)
- ☐ Diabetic retinopathy
- ☐ Other:

Family ocular history:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Retinal hole/tear/detachment
- ☐ Amblyopia (Lazy eye)/Strabismus (eye turn)
- ☐ Diabetic retinopathy
- ☐ Other:

Personal medical history:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other

Family medical history:

- ☐ Arthritis
- ☐ Cancer
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- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other

Social history:	Current	Former	Never
Tobacco use:	☐	☐	☐
Alcohol use:	☐	☐	☐
Marijuana use:	☐	☐	☐
Recreational drug use:	☐	☐	☐

How did you find us?

- ☐ Other patient (friend/family):
- ☐ Social media:
- ☐ Insurance:
- ☐ Google
- ☐ Window/walked by