Welcome to the Office of Dr. Simpson, O.D. and Dr. Sirois, O.D.

Patient Information:

Name: ____ Date of Birth: __________________

Address: ____ City: ________________ Zip Code: _________

Cell Phone: ______________________ Home Phone: ______________________

Social Security #: ______________________ Occupation: _________________ Employer: _________________

Email Address (optional): ____

Emergency Contact:

Name: ______________________________ Ph#___________________ Relationship_____________________

Vision Insurance Information:

Vision Insurance Name: ____________________________ Insurance ID #: ______________________________

Date of Last Eye Exam____________

Name of Family/Primary Doctor: _____________________________ Last Visit with Primary Doctor_________

Patient's Medical History:

Are **YOU** being treated for any conditions listed below? Y or N			Does any **family** member have any of the following? Please List below:
Diabetes	Yes	No	Relationship: _________
High Cholesterol	Yes	No	Relationship: _________
High Blood Pressure	Yes	No	Relationship: _________
Heart Disease	Yes	No	Relationship: _________
Cancer	Yes	No	Relationship: _________
Autoimmune Disorder	Yes	No	Relationship: _________
Cataracts	Yes	No	Relationship: _________
Glaucoma	Yes	No	Relationship: _________
Dry Eyes	Yes	No	Relationship: _________
Macular Degeneration	Yes	No	Relationship: _________
Retinal Detachment	Yes	No	Relationship: _________

List all **CURRENT** medications:

____

____

____

____

____

____

List all medication allergies:

____

____

____

List any type of surgery including eye surgery: ____

Do you wear glasses?	Yes	No
Do you wear contact lenses?	Yes	No
Are you interested in contact lenses?	Yes	No
Do you have trouble seeing at night?	Yes	No
Are you sensitive to glare or bright lights?	Yes	No

Are you having any problems with your vision? Yes No Please explain: ____

How did you hear about us? Your Insurance Internet Website Friend/Relative Primary Doctor Social Media

Patient/Guardian Signature: ____ Date: ____________________