EAST DALLAS FAMILY EYE CARE

8202 ELAM ROAD SUITE #100

DALLAS, TX 75217

(214) 391-1119

Welcome to our eye health clinic! We appreciate you choosing our eye care practice for your eye health care needs. Please complete this form in its entirely. If you have questions, please ask us for assistance. **ALL OF YOUR INFORMATION WILL BE KEPT CONFIDENTIAL, AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT.**

PATIENT INFORMATION

Date:

Name:

Last First M.I.

Address:_____City, State, Zip:

Date of Birth:_____ Social Security #:

Home Phone:_____Cell Phone:_____Work Phone:

Email Address (to confirm future appointments):

HEALTH INFORMATION

Do you currently wear glasses?:	Y	N
Do you currently wear contact lenses?:	Y	N
Interested in contact lenses?:	Y	N
Are you being treated for diabetes?:	Y	N
Do you work on a computer >4 hrs/day?:	Y	N
Are you experiencing more night visual blur?	Y	N
Do you drive a lot of night with your job?:	Y	N
Trouble seeing at night or driving at night?:	Y	N
Does your job require safety glasses?:	Y	N
Do you play sports and wear glasses?:	Y	N
History of head injury or concussions?:	Y	N

Last Eye Examination:_____ Where?:

Last Medical Examination:_____ Where?:

Name of Primary Care Physician and Office Address:

Drug Allergies:

Current Medications (OTC and by prescription) that you are currently taking:

Name of Primary Medical Insurance:

Name of Secondary Medical Insurance:

Name of Vision Insurance:

Name Insurance is Under & that person's Social Security Number:

Name of Primary Insured Employer: