NOVA OPTIQUE + EYECARE

Date:

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 (if different) Relationship to patient: Self Parent Spouse Other

Name: First Last

Address: Street DOB

SSN (last 4)

City State Zip

Phone: Home Cell Work

Email: Gender (for ins verification) F M

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:

Primary Care Provider:

Name:

Phone:

Fax:

Address:

Personal medical history:

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

Family medical history:

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

Social history: Current Former Never

Tobacco use:

Alcohol use:

Cannabis use:

Recreational drug use:

How did you find us?

Other patient (friend/family):

Social media:

Insurance:

Google

Window/walked by

Other: