LUXUR-EYES OPTOMETRIC CENTER
PATIENT INFORMATION SHEET

THANK YOU FOR CHOOSING LUXUR-EYES OPTOMETRIC CENTER, PLEASE TAKE THE TIME TO COMPLETELY FILL OUT THIS FORM. IF YOU HAVE ANY QUESTIONS PLEASE DO NOT HESITATE TO ASK.

GENERAL INFORMATION

FIRST NAME: _____ LAST NAME: _____ MI: _____
STREET ADDRESS: _____ APT #: _____
CITY, STATE, ZIP: _____
PRIMARY PHONE: _____ H W C SECONDARY PHONE: _____ H W C
E-MAIL: _____ DECLINE E-MAIL: ___

DATE OF BIRTH: _____ / _____ / _____ SOCIAL SECURITY NUMBER: _____ GENDER: M F

PREFERRED LANGUAGE: _____ DECLINE: _____

RACE:

- **____ AMERICAN INDIAN OR ALASKAN NATIVE**
- **____ ASIAN**
- **____ BLACK OR AFRICAN AMERICAN**
- **____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**
- **____ WHITE**
- **____ OTHER**
- **____ DECLINE**

ETHNICITY:

- **____ HISPANIC OR LATINO**
- **____ NOT HISPANIC OR LATINO**
- **____ DECLINE**

EMERGENCY CONTACT NAME: _____ PHONE NUMBER: _____
RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

INSURANCE INFORMATION

VISION INSURANCE: _____
PRIMARY MEMBER NAME: _____
VISION INSURANCE MEMBER ID # : _____
PRIMARY MEMBER DATE OF BIRTH: _____
LAST FOUR PRIMARY MEMBER SSN: _____
PATIENT RELATIONSHIP TO PRIMARY: SPOUSE | CHILD | OTHER: _____

MEDICAL INSURANCE: _____
PRIMARY MEMBER NAME: _____
MEDICAL INSURANCE MEMBER ID # : _____
PRIMARY MEMBER DATE OF BIRTH: _____
LAST FOUR PRIMARY MEMBER SSN: _____
PATIENT RELATIONSHIP TO PRIMARY: SPOUSE | CHILD | OTHER: _____

LUXUR-EYES OPTOMETRIC CENTER
PATIENT INFORMATION SHEET

TODAY'S VISIT

REASON FOR TODAY'S VISIT:

_____
_____
_____

PATIENT'S HISTORY

HAVE YOU OR A FAMILY MEMBER EVER BEEN DISAGNOSED OR TREATED FOR ANY OF THE FOLLOWING? CIRCLE ALL THAT APPLY.

CANCER	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**
TYPE 1 DIABETES	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**
TYPE 2 DIABETES	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**
HIGH BLOOD PRESSURE	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**
THYROID DYSFUNCTION	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**
CATARACTS	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**
GLAUCOMA	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**
MACULAR DEGENERATION	**SELF**	**MOM**	**DAD**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**N/A**

PLEASE LIST ANY CONDITIONS NOT LISTED ABOVE THAT YOU ARE DIAGNOSED OR UNDERGOING TREATMENT FOR:

_____
_____
_____
_____

PLEASE LIST ALL CURRENT MEDICATIONS WITH THE DOSAGE AND HOW OFTEN YOU TAKE THEM.
A SEPARATE LIST THAT WE CAN PHOTOCOPY IS ALSO APPROPRIATE:

_____
_____
_____
_____

PLEASE LIST ANY DRUG/MEDICATION ALLERGIES:

_____
_____

DO YOU USE TOBACCO PRODUCTS? YES | NO | FORMER USER
PREFERENCE? CIGARETTE | CIGAR | PIPE | SMOKELESS | OTHER: _____
AMOUNT: _____

DO YOU DRINK ALCOHOL? YES | NO AMOUNT: _____