Welcome to
TONGE EYE CARE

Today Date _____

Last _____First_____MI_____

Date of Birth_____Age_____SEX M F

Street_____

City_____State_____Zip_____

Home Phone_____

Work Phone_____

Cell Phone_____

Occupation (or grade)_____

Spouse (or parents name)_____

Email Address_____

What is the purpose of this visit?_____

Any Problem with your present contact lenses or glasses?_____

Smoker: ☐Yes ☐No ☐Quit, if quit when? _____

Weight: _____ Height: _____

Race: ☐White ☐Black or African American ☐Native Hawaiian

☐Hispanic ☐Asian ☐American Indian ☐Other _____

Who may we thank for referring you to our office?

Name:_____

Insurance Information

(Please provide your insurance card's and ID so we can make copy.)

Vision Insurance_____

Member Name_____

Member Social Security#_____

Member Birthday_____

Group/Plan#_____

Primary Medical Insurance_____

Member Name_____

Member ID#_____

Member Birthday_____

Group/Plan#_____

How will you settle your account today?

☐Cash ☐Check ☐Credit Card

Family Medical/Eye History

(check all that apply)

Is there a family medical history of any of the following?

	Relationship to patient
☐Blindness	_____
☐Cataracts	_____
☐Glaucoma	_____
☐Diabetes	_____
☐Macular Degeneration	_____

Patient Medical History

Name of Family Physician_____

Date of Last Physical Check-up_____

Current Medications_____

_____

Allergies to Medications: ☐Yes ☐No

_____

Have you ever been diagnosed or treated for the following?

☐Allergies	☐High Blood Pressure
☐Asthma	☐Kidney
☐Arthritis	☐Nerves
☐Cancer	☐Thyroid
☐Cholesterol	☐Diabetes
☐Heart Disease	☐Other_____

Patient Eye History

Date of Last Eye Exam_____

Do you wear Contact Lenses? ☐Yes ☐No

What Kind?_____

Solutions Used_____

Have you ever tried Contact Lenses?☐Yes ☐No

Do you…….*(Check box if your answer if Yes.)*

☐Work at a computer?

☐Think you might benefit from thinner lenses?

☐Have prescription sunglasses?

☐Prefer not to wear your glasses at times?

☐Want information on Laser Vision Surgery?

☐Have more than 1 pair of glasses?

Have you every been diagnosed or treated for the following?

☐Cataracts	☐Macular Degeneration
☐Corneal Abrasion	☐Retinal Detachment
☐Eye infection	☐Lazy Eye
☐Eye Injury	☐Other eye disorders
☐Glaucoma	_____
☐Iritis/Uveitis	

Do you experience or have ever experienced?

☐Blurry Vision	☐Sunlight Sensitivity
☐Burning	☐Uncomfortable glasses
☐Itchiness	☐Trouble seeing at night
☐Dryness	☐Flashes of lights
☐Headaches	☐Tearing

Signature_____Date_____