ELIZABETHTOWN EYE CARE

Established Patient Update

PLEASE PRINT

CONFIDENTIAL

Patient Name:			Date of Birth:
Address:			
Phone:	Cell Phone:	Email Address:	
Family Doctor (Name and Location):		Pharmacy (Name and Location):	
Preferred Language:	Race:	Ethnicity: Hispanic or Latino	Not Hispanic or Latino
Any changes any health or medications:		What eye drops are you currently using?	
		APPROXIMATE HEIGHT:	WEIGHT:
Reason for today's visit:			

Please circle all that may apply?

Frequent headaches	Night driving problems	double vision	Allergy or sinus problems
Eye Strain or Pain	Itching/burning/watering	poor distance/near vision	Problem with glare/headlights

Questions or Comments:

INSURANCE INFORMATION

Primary:	Policy Holder:	Date of Birth:	Social Security No.:
Secondary:	Policy Holder:	Date of Birth:	Social Security No.:

Signature of Patient/Responsible Party:	Date: