Welcome to
MARCIANO FAMILY VISION ASSOCIATES

PATIENT FORM

My information is the same as my last visit. ____YES (Please print your name, sign the bottom and continue to back)

DEMOGRAPHIC INFORMATION

Last, First, M:

Street Address: | Apt #:

City, State, Zip:

Home Phone: | Day Phone: | Cell Phone:

Email:

Preferred Contact Method: Phone Text Postal

Patient Social Security Number:

Date of Birth: | Male / Female

Employer: | Occupation: | Full Time Part Time

Marital Status: Married Single Divorced Widowed

Preferred Language: English Spanish | Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: Amer. Indian White Black/African American Hispanic Native Pac. Islander Asian

Emergency Contact Name & Number: | Whom May We Thank for Your Referral?

INSURANCE INFORMATION

	VISION	PRIMARY MEDICAL	SECONDARY MEDICAL OR VISION
Ins. Co. Name			
Insured's Name			
Identification #			
Group #			
Insured's DOB			
Insured's SS#			
Relation to Insured			

EYE HISTORY

Date of Last Eye Exam:

Currently Wear Glasses:

Currently Wear Contacts: How Many Hours a Day:

Reason for Today's Visit:

Have you had any eye surgeries or systemic surgeries since your last visit?

Have you or a family member, experienced, or been treated for, any of the following? Circle all that apply? Please name the family member.

Cataracts	SELF	Family:
Cross Eye	SELF	Family:
Glaucoma	SELF	Family:
LASIK or RK/PRK	SELF	Family:
Lazy Eye	SELF	Family:
Macular Degeneration	SELF	Family:
Retinal Detachment	SELF	Family:

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

Blurry Vision	Near
Blurry Vision	Distance
Burning	
Discharge	
Double Vision	
Dryness	
Excess Tearing / Watering	
Eye Infection	
Eye Pain or Soreness	
Floaters or Spots	
Halos	
Headaches	
Itching	
Light Flashes	
Light Sensitivity	
Redness	
Sandy or Gritty Feeling	

MEDICAL HISTORY

Date of Last Physical Exam:

Primary Care Doctors Name:

Primary Care Doctors Number:

Pharmacy:

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. Please name the family member.

AIDS / HIV	SELF	Family:
Allergies	SELF	Family:
Arthritis	SELF	Family:
Asthma	SELF	Family:
Blood / Lymph Disorder	SELF	Family:
Cancer	SELF	Family:
Diabetes	SELF	Family:
Ears, Nose, Throat Conditions	SELF	Family:
Gastrointestinal Conditions	SELF	Family:
Heart Disease	SELF	Family:
High Blood Pressure	SELF	Family:
High Cholesterol	SELF	Family:
Kidney Disease	SELF	Family:
Lupus	SELF	Family:
Neurological Conditions	SELF	Family:
Psychiatric Disorder	SELF	Family:
Seizures	SELF	Family:
Skin Conditions	SELF	Family:
Stroke	SELF	Family:
Thyroid Dysfunction	SELF	Family:

Current Medications:

Are you allergic to any medications?

Hobbies:	Sports:
Are you Pregnant or Nursing? :	
Do You Smoke?	How Often:
Do You Drink?	How Often:
Height:	Weight: