Bryant Vision Clinic

Patient Intake Form

General Information

First, Last, MI

Street Address

City, State, Zip

Phone ( ) Email

Preferred Method of Contact cell phone I email I text I other:

How did you hear about us?

Patient Social Security Number Date of Birth / /

Occupation/Employer

Language, Race, Ethnicity

Emergency Contact Person and Phone

Insurance Information

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID #

Primary Medical Insurance

Primary Member Name

Insurance ID #

Insurance Policy # / Group ID #

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Relationship to Primary Member spouse I child I other (please explain)

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID #

Secondary Medical Insurance Policy # / Group ID #

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member spouse I child I other (please explain)

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Eye History

Date of Last Eye Exam

Currently Wear Glasses? yes | no

Currently Wear Contacts? yes | no

Reason for Today's Visit

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

Cataracts	yes	no	family
Crossed Eye	yes	no	family
Glaucoma	yes	no	family
LASIK or RK	yes	no	family
Lazy Eye	yes	no	family
Macular Degeneration	yes	no	family
Retinal Detachment	yes	no	family

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

- ☐ Blurry vision — near | distance | both
- ☐ 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

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

AIDS / HIV	yes	no	family
Allergies	yes	no	family
Arthritis	yes	no	family
Asthma	yes	no	family
Blood / Lymph Disorder	yes	no	family
Cancer	yes	no	family
Diabetes	yes	no	family
Ears, Nose, Throat Conditions	yes	no	family
Gastrointestinal Conditions	yes	no	family
Heart Disease	yes	no	family
High Blood Pressure	yes	no	family
High Cholesterol	yes	no	family
Kidney Disease	yes	no	family
Lupus	yes	no	family
Neurological Conditions	yes	no	family
Psychiatric Disorder	yes	no	family
Seizures	yes	no	family
Skin Conditions	yes	no	family
Stroke	yes	no	family
Thyroid Dysfunction	yes	no	family

Current Medications (prescription, over the counter, and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing? **yes | no**

Do you smoke? **yes | no**

Have you ever smoked? **yes | no**