PATIENT INFORMATION

Personal Information

*Mandatory Fields

First Name*

Last Name*

Date of Birth*

Gender*

Preferred Language

Group*

Philadelphia Eyeglass Labs (1863 Street Rd., Bensalem, PA 19020

Exam Site*

Philadelphia Eyeglass Labs (1863 Street Rd., Bensalem, PA 19020)

Social Security Number (Must have last 4 Digits)*

Driver's License No.

Race/Ethnicity*

Occupation

Employer:

Referred By

Address Details

Address*

Country*

Zip Code*

City*

State*

Contact Information

*Mandatory Fields

Mobile Phone

*Please Enter One Contact Number

Home Phone

Work Phone

Extension Number

Email Address*

Emergency Contact Name

Emergency Telephone Number

Insurance Details

Insurance Company

Insured's First Name

Insured's Middle Name

Insured's Last Name

Insured's Identification Number

Insured's Group Number

Insured's Date of Birth

Patient Relationship to Insured

Login Details

* Mandatory Fields

Username*

Password*

Confirm Password*

Terms and Conditions

* Mandatory Fields

_____ I agree with Digital Optometrics Terms and Conditions and Privacy Policy.

Signature

* Mandatory Fields

Signature*

____ Date: _____________

Vision History Details *Mandatory Fields

Main Reason for today's Eye Exam*

Desk Computer Used Time (Hours Per Day)

Laptop/Tablet Used Time (Hours Per Day)

Sports

Hobbies

Have you worn contact lenses before?

YES NO

Contact Lenses Type

Are you interested in wearing contacts now?

YES NO

Are you interested in LASIK?

YES NO

Would you like thinner, lighter lenses for glasses?

YES NO

Do you currently wear glasses?

YES NO

Do you have a back-up pair of glasses?

YES NO

Do you have sunglasses?

With Prescription Transitions Without Prescriptions

Date of Last Eye Exam

Doctor's Name

Eye Vision History

Blurry Vision	Dry	Itchy Eyes
Loss of Vision	Stinging	Red Eyes
Double Vision	Gritty	Eyelid Infections
Halos	Tired Eyes	Flashes of Light
Glare	Watery	Floating Spots
Light Sensitivity	Mucous Discharge	Frequent Headaches

Please enter any other concerns that you may have regarding your eyes

Personal/Family Medical History (Do you or your Immediate Family have)

Arthritis

Self Parent(s) Sibling(s) Child(ren)

Cancer

Self Parent(s) Sibling(s) Child(ren)

Diabetes

Self Parent(s) Sibling(s) Child(ren)

Heart Disease

Self Parent(s) Sibling(s) Child(ren)

High Blood Pressure

Self Parent(s) Sibling(s) Child(ren)

Thyroid Disease

Self Parent(s) Sibling(s) Child(ren)

Skin Disorder

Self Parent(s) Sibling(s) Child(ren)

Asthma

Self Parent(s) Sibling(s) Child(ren)

Allergies

Self Parent(s) Sibling(s) Child(ren)

Eye Disease/Injury

Self Parent(s) Sibling(s) Child(ren)

Eye Surgery

Self Parent(s) Sibling(s) Child(ren)

Lazy Eye

Self Parent(s) Sibling(s) Child(ren)

Cataracts

Self Parent(s) Sibling(s) Child(ren)

Glaucoma

Self Parent(s) Sibling(s) Child(ren)

Macular Degeneration

Self Parent(s) Sibling(s) Child(ren)

Blindness

Self Parent(s) Sibling(s) Child(ren)

Other Medical History

Major Hospitalizations

Pregnant/Nursing?

Pregnant Nursing No

Primary Care Physician

Specialist

For

Specialist

For

Enter the medications you take on a regular basis

Are you allergic to any medications?

Do you drink alcohol?

Occasional 1 per Day 2-3/Day 4+/Day

Do you smoke?

Occasional ½ Pack/Day 1 Pack/Day 1+Pack/Day

Do you use illegal drugs?

Occasional 1 per Day 2-3/Day 4+/Day