# Welcome to Eye Envy, Where Style Matters!

**Name: (L)** _____ **(F)** _____ **Preferred Name:** _____

**DOB:** _____/_____/_____ **Age:** _____ **SSN:** _____ _____ **( insurance purposes)**

**Home Address:** _____ **City, State & Zip:** _____

**Email:** _____ **Phone Number:** _____

**Can you Receive Texts?** Yes ( ) No ( ) **Marital Status:** Single ( ) Married ( ) Other ( )

**Name of Parent, Legal Guardian or Spouse:** _____ **Phone Number:** _____

**Employer:** _____ **Occupation:** _____

**Race:** ( ) American Indian/ Alaskan Native ( ) Asian ( ) African American ( ) Native Hawaiian/Pacific Islander ( ) Caucasian ( ) Other _____

**Ethnicity:** Hispanic/ Latino ( ) Not Hispanic/ Latino ( )

**Vision Insurance Plan:** _____ **Policy Number or ID:** _____

**Policy Holders Name:** _____ **DOB:** _____/_____/_____ **Full SSN:** _____

**Please list any current medications & eye drops. (Prescriptions & over the counter medications)**

_____

**Please list any allergies to any medications you may have.**

_____

**Primary Care Doctor:** _____**Phone Number:** _____

**Preferred Pharmacy:** _____ **Location:** _____

**Do you wear glasses?** Yes ( ) No ( ) **Do you wear contacts?** Yes ( ) No ( ) **What Brand?** _____

**Please check any of the following that have ever applied to you.**

| | |
|---|---|
| ( ) Diabetes | ( ) Cataracts or ( ) Cataract Surgery |
| ( ) High Blood Pressure | ( ) Blurred Vision |
| ( ) Double Vision | ( ) Dry Eye |
| ( ) Eye Injury | ( ) Glaucoma |
| ( ) Gastrointestinal (Crohns/IBS) | ( ) Pregnant or Nursing |
| ( ) Floaters or Flashers | ( ) Auto Immune Diseases (Rheumatoid Arthritis, Lupus, Sjogrens) |
| ( ) Lazy/Crossed Eye | ( ) Loss of vision |
| ( ) Macular Degeneration | ( ) Headaches |
| ( ) Retinal Detachments | ( ) Trouble driving at night |

**Please list any medical conditions or illnesses you may have:** _____

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