WESTCHESTER
EYE CARE CENTER

Welcome! *Thank you for choosing our office! In order to serve you better, we need the following information.*

Patient Name:____

Parents Name (if a child):____

Address: ____ City:___________ State:_____ Zip: ________

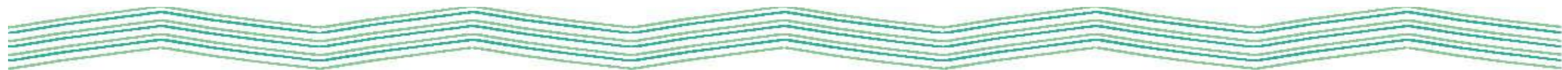
Home Phone:__________________ Work Phone: ______________________ Cell Phone: _______________________

Email:________________________________ ☐Male ☐Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Birthdate: ____________________ Age: ______________ Occupation: ____________________________________

Referred By (*we would like to thank them*) ____

Is this your first time to this office? ☐YES ☐NO



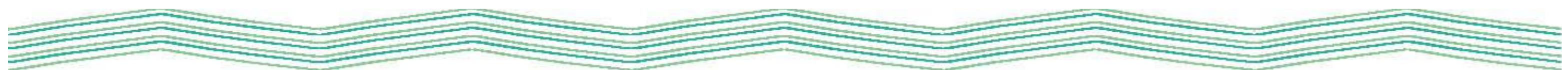
INSURANCE

Social security #:__________________________________ Employer: __________________________________

Patient relationship to insured: ☐ SELF ☐ CHILD ☐ DEPENDENT ☐SPOUSE

Vision Plan:______________________________________ ID#:____

Medical Plan: ____________________________________ ID#:____



OCULAR & HEALTH HISTORY

Main reason for consulting our office today: ____

When was your last eye exam? __________________ When was your last medical check-up?_____________________

Name of your primary care doctor: ____

Have you ever had eye surgery/injury? If so what kind and when?__________________________________

Are you currently taking medications? If so please list:____

Are you allergic to any medications? If so please list:____

Do you see any eye specialist? If so please list their name:_____________________________________

Do you use any eye drops? If so please list: ____

Do you have headaches/migraines? ☐ YES ☐ NO Are you pregnant? ☐ YES ☐ NO

Do you wear UV sun protection? ☐ YES ☐ NO Do you smoke? ☐ YES ☐ NO ☐ IN THE PAST

Do you wear contacts? ☐ YES ☐ NO ☐ IN THE PAST Brand:________________________ Solution:______________________

Would you like to use contacts if possible? ☐ YES ☐ NO

Do you use a computer for more than 1 hour a day? ☐ YES ☐ NO Do you feel strain at the computer? ☐ YES ☐ NO

What are you hobbies / sports? ____

PERSONAL HEALTH HISTORY: *Please mark off any conditions you have*

☐ Diabetes ☐ Thyroid Condition ☐ Anemia ☐ Heart Condition ☐ Allergies ☐ High Blood Pressure

☐ Arthritis ☐ High Cholesterol ☐ Cancer ☐ Stroke ☐ Syphilis ☐ Migraines ☐ Multiple Sclerosis

Other medical conditions not listed: ____

PERSONAL OCULAR HISTORY:

☐ Diabetes ☐ Retinitis Pigmentosa ☐ Cataracts ☐ Macular Degeneration ☐ Glaucoma ☐ Color Blindness

Other ocular conditions not listed:____

WHAT ARE YOU PRESENT OCULAR SYMPTOMS?

☐ Blurred near vision ☐ Dryness ☐ Itching ☐ Double Vision ☐ Mucous ☐ Eye Pain ☐ Floaters

☐ Blurred distance vision ☐ Redness ☐ Burning ☐ Light sensitive ☐ Flashes of light ☐ Watering

Other symptoms not listed:____

FAMILY HISTORY:

☐ Diabetes ☐ Retinitis Pigmentosa ☐ Cataracts ☐ Macular Degeneration ☐ Glaucoma ☐ Color Blindness

Have any of your family members been a patient at our eyecare center? If yes please name:_______________________________

____

I would like to know more about:

☐ No-line bifocals ☐ Photo-sensitive lenses ☐ Shatter resistant lenses ☐ Daily disposable Contacts

☐ Anti-glare lenses ☐ Scratch resistant lenses ☐ Bi-focal contact lenses ☐ Contacts for dry eyes/allergies

☐ Colored Contacts ☐ Light-weight thin lenses ☐ Computer glasses ☐Specialty dry eye treatments

☐ Backup glasses ☐ LASIK ☐Sport googles ☐ Special lenses for hobbies (i.e. golf)

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of benefits to Jennifer Tabibzadeh O.D. I understand that I will be financially responsible for payment of all charges, co-payments, and deductibles incurred for services rendered from this office:

Signature of patient or guardian:____ Date:_____________________________