

**WELCOME TO OUR OFFICE**

Dr. Matthew L. Gada

Mr. Mrs. Ms. Dr. \_\_\_\_\_ Nickname: \_\_\_\_\_

(Full Legal Name)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: M S D W

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse Work or Cell #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Responsible Party: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

(if different from above or patient is under 18, in the event of separation or divorce the CUSTODIAL Parent is responsible for payment, Eye 2 Eye will not be involved in collecting payment from the non-custodial parent.)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Personal and Family Medical History (Please Specify Relationship to you)

Glaucoma Y/N \_\_\_\_\_ Blindness Y/N \_\_\_\_\_ Cataracts Y/N \_\_\_\_\_ Eye Surgery Y/N \_\_\_\_\_ Eye Turn Y/N \_\_\_\_\_  
Retinal Disease Y/N \_\_\_\_\_ Macular Degeneration Y/N \_\_\_\_\_ Strabismus Y/N \_\_\_\_\_ Eye Injury Y/N \_\_\_\_\_  
Diabetes Y/N \_\_\_\_\_ High Blood Pressure Y/N \_\_\_\_\_ Thyroid Y/N \_\_\_\_\_ Cardio Y/N \_\_\_\_\_

Other: (please list)

Please list all medications that you are presently taking and the reason you are taking them:

Please list all Allergies:

Eye Information

Date of Last Exam: \_\_\_\_\_  
By Dr.: \_\_\_\_\_  
Do you wear glasses: \_\_\_\_\_  
Do you wear Sunglasses: \_\_\_\_\_  
Are they Polarized: \_\_\_\_\_  
Age of Current Glasses: \_\_\_\_\_  
Type of Lenses: \_\_\_\_\_  
*Distance Near BiFocal*  
Does the weight of your glasses bother you: \_\_\_\_\_  
Does Glare bother you: \_\_\_\_\_  
Would you like to see without your glasses: \_\_\_\_\_  
Are you interested in Laser Vision Correction: \_\_\_\_\_

Contact Lens Info.

Do you wear Contact Lenses: \_\_\_\_\_  
If no, would you like to: \_\_\_\_\_  
Type of Lenses: \_\_\_\_\_  
Average Wearing Time: \_\_\_\_\_  
Cleaning Solution Used: \_\_\_\_\_  
How often do you dispose of them: \_\_\_\_\_  
Would you be interested in Contact Lens Corneal Refractive Therapy: \_\_\_\_\_

Visual Needs

Skiing Sewing Contact Sports Reading  
Swimming Tennis Arts & Crafts Golf  
Computer Cycling Basketball Fishing  
Hunting Home Workshop Baseball Running

Other:

By signing below, I certify that the above information is true and correct to the best of my knowledge. I will notify Eye 2 Eye Optometric Center of any changes in my information.

Signature

Relation to Patient

Date