

McMinnville Family Eye Care, LLC
2185 NW 2nd St, Suite A
McMinnville, OR. 97128
(503) 435-1231

PATIENT INFORMATION

Ms. Mrs. Mr. Dr. _____
Address _____ Phone _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____
Name of Parent/Guardian if under 18 years old _____
Occupation _____ Hobbies _____
Primary Care Physician _____ Clinic _____
Last Eye Exam _____ Last Medical Exam _____

INSURANCE INFORMATION

Medical Ins Name _____
ID # _____ GROUP# _____
Vision Ins Name _____
ID # _____ GROUP# _____

THANK YOU FOR COMING IN

How did you hear about our office? Please check all that apply:
___ Insurance ___ Newspaper ___ Phone Book ___ Walk-In
___ Personal Referral, name _____

CORRECTIVE LENS HISTORY

Do you wear glasses? YES NO
If yes, what type? ___ Single Vision ___ Progressive ___ Bifocal ___ Trifocal
Do you wear contacts? YES NO
If yes, what type? ___ Soft ___ Rigid Gas Perm
How often do you replace them? ___ 2 weeks ___ 1 month ___ annually
Do you sleep in your lenses? ___ every night ___ occasionally

MEDICAL HISTORY

Please list any medications you take and the reason for taking them: _____

Do you have any **allergies to medications**? _____

Who should we contact in case of an emergency?
Name _____ Phone # _____

(continued on next page) **MEDICAL HISTORY CONTINUED:**

Do **you** have any of the following:
___ Blurry Vision ___ Eye Strain ___ Eye Pain / Headaches
___ Sandy / Gritty Eyes ___ Watery Eyes ___ Itchy Eyes
___ Glaucoma ___ Diabetic Retinopathy ___ Macular Degeneration

