

EYE TRENDS

Shini OD, PA
College Station, TX

PATIENT INFORMATION			
Name:	DOB:	Age:	SS#:
Address:	City:	State:	Zip
Home Ph:	Work Ph:	Cell Ph:	Email:
Health Insurance:	Vision Insurance:		

INSURANCE POLICY HOLDER INFORMATION (If different from above.) GUARDIAN INFORMATION IF UNDER 18			
Name:	DOB:	Age:	SS#:
Address:	City:	State:	Zip
Home Ph:	Work Ph:	Cell Ph:	Email:
Health Insurance:	Vision Insurance:		

HIPPA ACKNOWLEDGEMENT OF RECEIPT	
I acknowledge that I have received a copy of Eye Trends- College Stations (Shini OD, PA) Notice of Privacy Practice: PATIENT NAME (Print): _____ SIGNATURE (Parent or Guardian if under 18): _____	

I hereby authorize Eye Trends-College Station (Shini OD, PA) to obtain my insurance information and bill my insurance company for services received at this office. In the event that my insurance denies the claim I will be solely responsible for the charges incurred. PATIENT NAME (Print): _____ SIGNATURE (Parent of Guardian if under 18): _____	
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How did you hear about our office? (Please circle one)				
Yellow Pages	Walk In	Doctor Referral	Insurance	Internet
Newspaper	Mail	Employer	Personal Referral	
If patient referral, whom may we thank: _____				

EMPLOYMENT	
Employer:	Occupation:
School (If student):	Grade Level:
Do you work on a computer, if yes how many hours a day?	

EXTRACURRICULAR ACTIVITIES
Please list your hobbies and any activities that you participate in that requires eye protection:

MEDICATIONS AND ALLERGIES

Please list all medications that you are taking, including birth control, vitamins, herbs and over-the-counter:

Please list any known drug allergies:

Do you have general/seasonal allergies? (If yes explain)

OCULAR REVIEW OF SYMPTOMS

What is your reason behind today's visit?

When was your last eye exam?

Who was your last Eye Doctor?

Who is your General Physician?

Do you currently:

Wear Glasses Yes No If yes, how old are they?

Wear Contacts Yes No If yes, what brand are they? Do you sleep in them? Yes No

Use eye drops Yes No If yes, why and what is the name of them?

Are you interested in Laser Vision Correction? Yes No If yes how soon?

Please circle any of the following symptoms that you are experiencing.

- | | | | | |
|----------------------------|------------------|----------------------|---------------------------|-------------------|
| Blurred Vision | Tearing/Watering | Flashes of Light | Glare | Light Sensitivity |
| Discharge | Red Eyes | Loss of Vision | Eye Pain | Double Vision |
| Burning | Dryness | Chronic Infection | Irritation | Itching |
| Foreign Body Sensation | | Floating Spots | Distorted Vision/Halos | |
| Difficulty w/Night Driving | | Tunnel-Vision | Loss of Peripheral Vision | |
| Fluctuating Vision | | Sandy/Gritty Feeling | | |
| Eye Strain with Computers | | Other Symptoms: | | |

Have you ever had any type of injury or surgery to your eye? Yes No

If yes what was the nature of the injury/surgery? _____

If yes when did the injury/surgery occur? _____

Who was your Physician? _____

Have you ever had any type of head trauma? Yes No

If yes, what was the nature of the injury? _____

If yes, when did the injury occur? _____

Who was your Physician? _____

Are you pregnant or nursing? Yes No

MEDICAL/OCULAR PERSONAL AND FAMILY HISTORY

Please check any condition that applies to your and/or a family member:

	Self	Family (Relation)		Self	Family (Relation)
Diabetes	_____	_____	Retinal Detachment	_____	_____
Blindness	_____	_____	Cancer	_____	_____
Heart Problems	_____	_____	Double Vision	_____	_____
Lazy Eye	_____	_____	High Blood Pressure	_____	_____
Cataracts	_____	_____	Loss of Vision	_____	_____
Headaches	_____	_____	Respiratory Problems	_____	_____
Stroke	_____	_____	Macular Degeneration	_____	_____
Glaucoma	_____	_____	Thyroid Problems	_____	_____