BELLBROOK VISION CENTER

SPRINGBORO EYE CARE

Please contact me by:

- ❏ Phone call
- ❏ Text
- ❏ Email

Today's Date:_____/_____/_____

First Name:_____ Initial:_____ Last Name:_____

Date of Birth:_____/_____/_____ Social Security Number (Last 4 Digits): _____

Phone number: _____ Email:_____

Guardian/Emergency Contact:_____Phone Number:_____

Date of last eye exam: _____

Reason for Visit: _____

Have you worn glasses? YES / NO If Yes, how old are your current glasses _____

Have you worn contact lenses? YES / NO If yes, how old are your current contacts _____

- How often do you replace your contact lenses (please circle) DAILY BIWEEKLY MONTHLY

Do you or a family member have…	**SELF**	**FAMILY**		**SELF**	**FAMILY**
High Blood Pressure			**Macular Degeneration**		
High Cholesterol			**Glaucoma**		
Diabetes			**Flashes and Floaters**		
Amblyopia (Lazy Eye)			**Cataracts**		
Retinal Detachments			**Are you Pregnant or Nursing?**		
Keratoconus			**Are you a smoker?**		

MEDICATIONS: Please provide any prescription medications you are taking OR a copy of your medication list:

_____

Please list any allergies to medications you are aware of:

_____

Please list any previous surgery or injury you may have had for your eyes:

_____

Who is your primary care physician?_____ Fax #: _____

Preferred Pharmacy: _____ Address:_____