PACIFIC DIRECT EYE CARE

Patient Intake Form

Patient Information

Full Name: _____

Date of Birth: _____ Age: _____

Gender: Male Female Other Prefer not to say

Phone Number: _____

Email Address: _____

Address: _____

City: _____State: _____ Zip: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Insurance Information

Medical Insurance: Yes No

Provider: _____ Member ID: _____

Reason for Visit

Routine Eye Exam Vision Changes Eye Pain Redness/Irritation

Dry Eyes Contact Lens Exam/Fitting Injury/Trauma

Other: _____

Current Vision Status

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Brand: _____ Replacement Schedule: _____

Date of Last Eye Exam: _____

Ocular History

Glaucoma Cataracts Macular Degeneration Retinal Disease

Dry Eye Syndrome Eye Infection Eye Injury/Surgery

Amblyopia Strabismus None

If yes, explain: _____

Medical History

Primary Care Physician: _____

Date of Last Physical: _____

Diabetes High Blood Pressure Heart Disease Thyroid Disease

Autoimmune Disease Neurological Conditions Migraines None

Other: _____

Medications

List all medications (including eye drops):

_____

_____

Allergies

No Known Allergies

Medications: _____

Environmental: _____

Family Ocular History

Glaucoma Macular Degeneration Retinal Disease Blindness None

Social History

Occupation: _____

Screen time per day: _____ hours

Do you smoke? Yes No

Do you drink alcohol? Yes No

Review of Systems (Eye Related)

Blurred Vision Double Vision Floaters/Flashes Light Sensitivity

Eye Pain Headaches Dryness/Burning Tearing None

Financial Policy Acknowledgment

Pacific Direct Eye Care operates with a **patient-centered, transparent care model**. Payment is due at time of service unless prior arrangements are made.

☐ I understand and agree to financial responsibility for services rendered.

Name and Contact information for financially responsible party (if different than patient):

_____

Consent & Acknowledgment

I certify that the above information is accurate to the best of my knowledge. I consent to examination and treatment as deemed necessary by the provider.

Signature: _____ Date: _____