Siri Premier Eyecare
Compassionate & Comprehensive Eyecare

724 Cambridge Plaza
Cambridge, MD 21613
Phone: 443-515-9278 Fax: 833-940-2191

Date: _____ **Email:** _____

Last Name:_____ **First Name:**_____ **SSN:**_____

Address:_____ City:_____ State:____ Zip Code:_____

Home Phone: _____ Work Phone: _____

Employer: _____Occupation:_____ DOB: _____ Age: _____

INSURANCE
Primary Insurance: _____
Primary Insurer's name: _____
Insurance ID#: _____
Insurance Group#: _____

Need (Circle All That Apply)? Glasses/ Contacts/ Flashes/ Floaters/ Red eye/ Pain/ Double vision
How many hours do you spend on the computer/ Day? _____
At the end of the Day (Circle All That Apply): My eyes feel tired/ I have headaches/ Eyes feel dry

PERSONAL OCULAR HISTORY: CHECK ALL THAT APPLY
( ) Wears Glasses
( ) Wears Contact lenses
( ) Lazy Eye
( ) Eye Surgery
( ) Eye Trauma/ Injury
( ) Cataract
( ) Macular Degeneration
( ) Glaucoma
( ) Blindness
( ) Other _____

PERSONAL MEDICAL HISTORY: CHECK ALL THAT APPLY
( ) Diabetes Type 1 / 2 (circle one)
( ) High Blood Pressure
( ) High Cholesterol
( ) Thyroid Disease
( ) Autoimmune Disease (SLE, Lyme, Rheumatoid Arthritis)
( ) Heart Disease
( ) Stroke

( ) Cancer
( ) HIV/AIDS

FAMILY OCULAR HISTORY: CHECK ALL THAT APPLY
( ) Lazy Eye
( ) Cataract
( ) Macular Degeneration
( ) Glaucoma
( ) Blindness
( ) Other _____

FAMILY MEDICAL HISTORY: CHECK ALL THAT APPLY
( ) Diabetes
( ) High Blood Pressure
( ) Stroke
( ) Cancer

SOCIAL HISTORY: CIRCLE ALL THAT APPLY
NON-SMOKER? YES/ NO
CURRENT SMOKER? YES/ NO ½ PACK/DAY 1 PACK/DAY >1 PACK A DAY
FORMER SMOKER? YES
DO YOU DRINK? YES/ NO
BLOOD TRANSFUSION? YES/ NO

CURRENT MEDICATIONS: _____
_____
CURRENT DOCTOR/S: _____

ALLERGIES TO MEDICATIONS: YES NO
IF YES, WHICH MEDICATION AND REACTION?

ARE YOU PREGNANT? YES NO
IF YES, # MONTHS? _____

*All professional fees/ copays are due at the time of service
*NO REFUNDS. STORE CREDIT ONLY

PATIENT SIGNATURE _____ DATE: _____