CUSHING VISION CENTER

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Date: _____

Patient Full Legal Name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Sex: ❒M ❒F Marital Status: ❒S ❒M ❒D ❒W

SSN: ____/____/_____ Name of Spouse/ Parent: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Additional Phone: _____

Employer: _____ Employer Phone: _____

Occupation: _____

Email: _____

Ethnicity: _____

Insurance Information: (please provide cards)

Primary Vision Ins: _____ Policy #: _____

Name of Insured: _____ Insured DOB: _____

SSN or last four of SSN: _____

Primary Medical Ins:_____ Policy #: _____

Name of Insured: _____ Insured DOB: _____

SSN or last four of SSN: _____

Family Physician: _____ Physician #:_____

Pharmacy: _____ Pharmacy #:_____

How did you hear about us? _____

Patient Medical History

Name: _____ DOB: _____/____/_____

Eye History: When was your last eye exam: _____Previous Eye Doctor_____
Do you currently wear ❒ Glasses and/or ❒ Contacts
Are you interested in laser vision correction (LASIK)? ❒ Yes ❒ No
Previous Eye Surgeries and Injuries with Approximate Dates: Check if None ❒

_____ _____ _____

Current eye medication: Check if None □

_____ _____ _____

What are your current symptoms? (Check all that apply)
❒Blurry Vision ❒Burning ❒Headaches ❒Double Vision ❒Flashes of Light
❒Floaters/Spots ❒Grittiness ❒Itchiness ❒Dryness ❒Crossed Eye
❒Poor Night Vision ❒Bothered by glare

Please check All that apply:	You	Family		You	Family
Blindness:	❒	❒	Glaucoma:	❒	❒
Cataract:	❒	❒	Macular Degeneration:	❒	❒
Crossed/Lazy Eyes:	❒	❒	Retinal Detachment:	❒	❒
Other: _____	❒	❒	Other: _____	❒	❒

Health History:

List of medication Allergies: Check if None ❒

_____ _____ _____

List of Current Medication: Check if None ❒ Check if you have a list we can copy ❒

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please check all that apply:	You	Family		You	Family
Allergies:	❒	❒	Heart Disease:	❒	❒
Anemia:	❒	❒	High Blood Pressure:	❒	❒
Arthritis:	❒	❒	High Cholesterol:	❒	❒
Asthma:	❒	❒	Kidney Disease:	❒	❒
Cancer: _____	❒	❒	Lung Disease:	❒	❒
Diabetes: ❒I ❒ II	❒	❒	Lupus:	❒	❒
Depression:	❒	❒	Sinus Problems:	❒	❒
Headaches:	❒	❒	Thyroid Disease:	❒	❒

Do you smoke or vape: ❒yes ❒no **Do you use smokeless Tobacco?** ❒yes ❒ no

Please sign that you have reviewed all information above and it is correct to the best of your knowledge.

Patient/Guarantor: _____ Date: _____/_____/_____