CEDAR CREST VISION

ROBERT H. QUICK, OD 505.286.0300

NEW PATIENT INFORMATION

Patient Name			Date of Birth		
Address			SSN		
City		State		Zip	
Home Phone		Cell Phone			
Work Phone		Email			
Gender		Preferred Language			
Primary Physician		Physician Phone #			
Guarantor Name		Guarantor Phone #			

VISION INSURANCE INFORMATION

Insurance Co.		Insurance Phone	
Insurance ID#		Group #	
Insured's Name		Insured's SSN #	
Insured's D.O.B.	Relationship	(check one) Self___ Spouse___Child___Other___	

Vision Plans cover "well vision" exams. Any medical history or diagnosis will result in the visit being billed to your medical insurance.

PRIMARY MEDICAL INSURANCE INFORMATION

Insurance Co.		Insurance Phone	
Insurance ID#		Group #	
Insured's Name		Insured's SSN #	
Insured's D.O.B.	Relationship	Self___Spouse___Child___Other___	

SECONDARY MEDICAL INSURANCE INFORMATION

Insurance Co.		Insurance Phone	
Insurance ID#		Group #	
Insured's Name		Insured's SSN #	
Insured's D.O.B.	Relationship to Patient	Self___ Spouse___Child___Other___	

List of medications you currently take and for what condition:

Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for :_____
Medication: _____ used for ;_____
Medication: _____ used for ;_____
Medication: _____ used for ;_____

Date of last eye exam:_____

Eye injuries and surgeries with dates:_____

_____

Drug Allergies or other Allergens: _____

CONTINUED ON BACK

PERSONAL HEALTH HISTORY (check if yes)

Eyes (current symptoms & history)
☐ none
☐ dry eyes
☐ eye pain
☐ eyelid swelling
☐ floaters
☐ flashes
☐ itching eyes
☐ light sensitivity
☐ cataract
☐ glaucoma
☐ macular degeneration
☐ surgery
☐ other_____
☐ eye drops or eye medications_____
_____

Allergic/Immunologic
☐ none
☐ drug allergy
☐ hay fever/seasonal
☐ rheumatoid arthritis
☐ lupus
☐ other_____

Cardiovascular
☐ none
☐ heart disease
☐ hypertension
☐ stroke
☐ other_____

Constitutional
☐ none
☐ fatigue
☐ weight loss/gain
☐ other_____

Ears, Nose, Throat
☐ none
☐ hearing problems
☐ sinus problems

Ears, Nose, Throat (cont.)
☐ TMJ disorder
☐ upper resp. infection
☐ other_____

Endocrine
☐ none
☐ diabetes
☐ high/low blood sugar
☐ thyroid dysfunction
☐ hormonal dysfunction
☐ other_____

Gastrointestinal
☐ none
☐ colitis
☐ crohn's
☐ ulcer
☐ other_____

Genitourinary
☐ none
☐ kidney problems
☐ renal failure
☐ dialysis
☐ sexually transmitted disease
☐ other_____

Hematologic/Lymphatic
☐ none
☐ anemia
☐ leukemia
☐ cancer
☐ HIV
☐ other_____

Musculoskeletal
☐ none
☐ fibromyalgia
☐ muscular dystrophy
☐ osteoarthritis
☐ other_____

Pregnant ☐ yes ☐ no

Neurological
☐ none
☐ multiple sclerosis
☐ epilepsy
☐ migraines
☐ other_____

Psychiatric
☐ none
☐ depression
☐ bipolar
☐ other_____

Respiratory
☐ none
☐ cigarette smoker
☐ asthma
☐ bronchitis
☐ emphysema
☐ other_____

Skin/Integumentary
☐ none
☐ eczema
☐ rosacea
☐ psoriasis
☐ other_____

Alcohol use
☐ yes _____
☐ no

Tobacco use
☐ yes _____
☐ no

Marijuana use
☐ yes _____
☐ no

FAMILY HEALTH HISTORY (check if yes, please indicate relationship to patient, i.e. Mother, Father, Grandparents, Siblings)

☐ cancer - _____
☐ diabetes_____
☐ heart disease - _____
☐ high blood pressure - _____
☐ stroke - _____
☐ glaucoma - _____
☐ cataracts- _____
☐ macular degeneration- _____
☐ other - _____