## Dr Philip Gaskins and Associates

PATIENT INFORMATION (PLEASE PRINT) DATE: ____________________

Patient's Name Birth Date Sex Last Exam

Patient's Address Primary Phone #

Occupation or Student Employer or School Phone #

Spouse or Parent's Name Address (if different) Primary Physician

Health Insurance Company Insured's Name Policy and Group #

Current Medications Currently Pregnant?

Allergies (Medication, Substances) Hobbies or Special Visual Needs

Reason for Visit Preferred E-Mail Address (recalls)

| **Have You or Family Had:** | **You** | **Blood Relative** | **Have You Had:** | |
|---|---|---|---|---|
| Cataracts | | | Watery Eyes | |
| Glaucoma | | | Burning Eyes | |
| Retinal Detachment | | | Itchy or Red Eyes | |
| Eye Disease | | | Red Eyes | |
| Eye Surgery | | | Eye Pain | |
| Diabetes | | | Problem Headaches | |
| High Blood Pressure | | | Double Vision | |
| Heart Problems | | | Eye Injury | |
| Convulsions/Epilepsy | | | Flashes of Light | |
| Thyroid Problems | | | Head Trauma | |

**Do You Currently Wear:**

Glasses_______ Contacts_______ Contact Lenses Tried__________________________ Interested In Contacts? ________

**Please Sign Below to Attest and Authorize Insurance Filing:**

_____________________________________________

Patient or Guardian