Total EyeCare and Aesthetics

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Tel 516-681-2220/ Fax 516-681-2214

Patient Information:

Name: _____

Date: _____

Date of Birth: _____

Address: _____

_____

Cellular phone: _____

Work phone: _____

Email: _____

Occupation: _____

Emergency Contact:

Name: _____

Phone: _____

Relationship: _____

Insurance Information:

Primary: _____

Secondary: _____

Policy Holder (if not the patient) Name: _____

Pharmacy Information:

Name: _____

Location: _____

Mail Order Pharmacy (if applicable): _____

Primary Care Physician:

Primary Care Physician name: _____

Primary Care Physician phone: _____

Medical / Ocular History:

Please list any existing medical problems: _____

_____

Please list any previous surgeries: _____

_____

Please list current medications: _____

_____

Please list any eye diseases and previous ocular surgeries, or family history of eye disease:

_____

Please list all ocular medications:_____

_____

Please provide glasses and contact lens information: _____

_____

Please list any allergies/ medical allergies/ reactions to eyedrops: _____

_____