DAVID B. BRILL, O.D., P.A.

PATIENT INFORMATION

Personal Information

Date _____ Social Security # _____

Full Name _____ Date of Birth _____

Address _____ I authorize the release of any information needed to process my insurance claim.

_____
City State Zip

Telephone H _____ W _____

Occupation _____ Signed _____

General

How did you learn about our office? ☐ Newspaper ☐ Radio ☐ Television ☐ Yellow pages ☐ A Friend or Relative
☐ Walk By ☐ Insurance Company/Third Party Adminstrator ☐ Other ☐ I am a previous patient.
☐ Referred by another patient. Referred by _____

Health Information

Reason for this visit: ☐ Routine Exam ☐ Contact Lens fitting ☐ Interested in Contact Lenses

☐ Other (please explain) _____

_____

Last Eye Exam _____ Dr. _____

Have you ever had any injury or surgery to or around your eyes? ☐ Yes ☐ No

Please describe _____

Last physical exam _____ Dr. _____

Are you currently taking any medications? ☐ Yes ☐ No (include eye drops, hormones and birth control)

Please list all medications: _____

Family Health History: (Please check all that apply)

Do you wear contact lenses? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

	You	Blood Relative		You	Blood Relative
Glaucoma	☐	☐	Diabetes	☐	☐
Cataracts	☐	☐	High / Low Blood Pressure	☐	☐
Lazy Eye	☐	☐	Heart / Vascular Disorders	☐	☐
Blindness	☐	☐	Thyroid Trouble	☐	☐
Allergies	☐	☐	Cancer/ Tumors	☐	☐
Color Blindness	☐	☐	Retinal Disease	☐	☐
Intestinal / Digestive Disorder	☐	☐	Asthma / Bronchitis / Lung Disorder	☐	☐
Kidney / Liver Disorder	☐	☐	High / Low Blood Sugar	☐	☐
Arthritis	☐	☐	Other	☐	☐
Fainting / Dizziness	☐	☐			

By signing below I acknowledge that my records will be handled by Dr. Brill's staff.

Patient's Signature _____