Eye Associates

10801 Hickory Ridge Road #200, Columbia, MD 21044

Patient Information Update

Patient Name: _____ Date: _____

Address: _____ Mobile# _____

_____ Home# _____

Email Address: _____

Who do we have to thank for your referral? _____

Do you give Eye Associates permission to email or text you regarding your annual recall, upcoming appointment, purchased products ready for pickup and to share any promotions? Y or N

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Current Medical Insurance: _____ID:_____

Current Vision Insurance: _____ID:_____

(Please provide a copy of ALL your medical insurance cards and driver's license)

Primary Care Provider

Name: _____ Last Physical exam_____

Office #: _____ Fax #: _____

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Eyes feel (circle): Dry Sandy/Gritty Red Burning Watery Itchy Pain Light Sensitive Discharge None Other: _____

Hours of computer/screen time: _____ hours/day

Medical Conditions (circle): Diabetes (Type 1 or Type 2) High Blood Pressure High Cholesterol Heart Disease Thyroid Condition Cancer Autoimmune Disease

Other: _____

List ALL **medications** taken: _____

_____

_____

List ALL **drops** taken: _____

Do you have any known **drug allergies**? _____

Patient Signature: _____ Date: _____