North Texas Center for Sight

PLEASE FILL OUT ALL BLANKS COMPLETELY

PATIENT INFORMATION

Name: ____ Date of Birth:______________ Age: _______

Address: _____________________________________ City: ________________ State: _____ Zip: ________

Home Phone #: _____________________ Cell Phone #: ________________ Work Phone # _____________

Email: ____ Social Security #: _________________________

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: □ African American □ Asian Pacific □ Caucasian □ Hispanic □ Native American □ Other ______

Occupation: __________________________________ Employer: ___________________________________

Emergency Contact Name: ______________________________________ Phone #: ___________________

Primary Care Physician: ____ Phone #: ____________________

Date of Last Eye Exam: ________________ Name of previous eye Dr: ______________________________

REASON FOR TODAY'S VISIT

□ Routine Eye Exam □ Cataract Evaluation □ Glaucoma Evaluation □ Retinal Evaluation
Other: ____

Please let us know about your history and family history of eye related problems and indicate whom below:
□ Diabetes: ____
□ Glaucoma: ____
□ Age Related Macular Degeneration: ____

HOW WERE YOU REFERRED TO US

Were you referred by a doctor? Name: _________________________ Specialty: _________________

Were you referred by a friend/ family? Name: ____