



**Dr. David J. Sobel, O.D., LLC**  
*"Excellence in Eye Care since 1984"*



**Check Yearly  
See Clearly.**

Thank you for giving us the opportunity to care for your **Eye Health & Vision** Care needs.  
 We know there are many eye care alternatives and we really do *appreciate your business!*  
 Please take **5 minutes** to complete this **Patient History Form**. If you need help please ask.

**Check Yearly  
See Clearly.**

Today's Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female Soc. Sec # \_\_\_\_\_  
**Patient Name**  Dr  Mr  Mrs  Ms  Miss \_\_\_\_\_ eMail Address \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Tel/Home \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_ Tel/Work \_\_\_\_\_  
 Cell # \_\_\_\_\_

If minor, Parent's Name(s) \_\_\_\_\_ If married, Spouse's Name \_\_\_\_\_  
 Family members "examined" in this office \_\_\_\_\_  
 How did you hear about us?  Yellow Pages  Insurance Plan  Village Green Plaza Sign  Neon Sign  Web Site  
 Relative/Who? \_\_\_\_\_  Friend/Who? \_\_\_\_\_  Other/Who? \_\_\_\_\_

Who may we thank for this referral? \_\_\_\_\_

What was your last Eye Doctor's Name? \_\_\_\_\_ City/ST \_\_\_\_\_ Last Exam Date \_\_\_\_\_

**Specific Reason for Today's Exam?**

- Yearly  Over-Due  Not Seeing Clearly  Scratched Lenses  Want/Need New Frames  Update Contact Lenses  
 Interested in Contact Lenses  Other/Explain \_\_\_\_\_

**Have you ever worn prescription glasses before?**  Yes  No (If Yes, for  Distance  Near  Computer)  FT  PT  
 On average, "how long" do you stare at a Computer Screen for per day? \_\_\_\_\_ hour(s)  
 Did you know there are huge benefits of wearing a Computer-Specific pair of eyeglasses?  Yes  No

**If you've worn contact lenses before, what kind?**

- Soft  Gas-Permeable  Daily Wear  Over-Night Wear  Yearly  Disposable  Color  Toric/Astigmatism  MonoVision  Bifocal

Who is Your Primary Care Physician? \_\_\_\_\_ City/ST \_\_\_\_\_ Last Seen \_\_\_\_\_

How would you rate "your" **General Health**?  Excellent  Very Good  Good  Fair  Poor

Are you a smoker?  Yes  No What Vitamins/Minerals/Herbs do you take "daily"? \_\_\_\_\_

**Check all that apply**

	<u>Self</u>	<u>Family</u>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Head Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	_____ mos.

	<u>Self</u>	<u>Family</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degen.	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>
Floater	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Vision Training	<input type="checkbox"/>	<input type="checkbox"/>

**Do you currently have**

Blurry Distance Vision	<input type="checkbox"/>
Blurry Near Vision	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>
Red Eyes	<input type="checkbox"/>
Itchy Eyes	<input type="checkbox"/>
Watery Eyes	<input type="checkbox"/>
Dry Eyes/Burning	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>
Night Blindness	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>
Glare Sensitivity	<input type="checkbox"/>

**List all Prescription & Over-The-Counter Medications:**

1. \_\_\_\_\_ 4. \_\_\_\_\_  
 2. \_\_\_\_\_ 5. \_\_\_\_\_  
 3. \_\_\_\_\_ 6. \_\_\_\_\_

Medical Health Insurance Plan \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Payment Terms:** *Unless you have Health Insurance Coverage, payment is required "at-the-time-of-service" !*  
*We are happy to assist you in the submitting of your Health Insurance Claim. "By signing below I hereby authorize payment of my medical benefits to **Dr. David J. Sobel, O.D., LLC**. I hereby authorize **Dr. Sobel** to release any information required to process this claim. I understand that I am financially responsible for any non-covered services and materials".*

Please SIGN HERE X \_\_\_\_\_ Date \_\_\_\_\_