Dr. David J. Sobel, O.D., LLC.

Excellence in Eye Care Since 1984

Check Yearly. See Clearly.℠

29 West Street Litchfield, CT 06759 ☎ 860·567·4565 drdavidsobel.com

We look forward to providing you with the best care for your Eye Health & Vision. Kindly take a few minutes to complete this Patient History Form, call us if you have questions or need assistance. See you soon!

Patient's Name ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss _____ Date ___/___/_____

D.O.B ___/___/_____ ☐ Male ☐ Female Email _____

Parent/Legal Guardian's Name (if Patient is a minor) _____ Spouse _____

MAILING ADDRESS & CONTACT INFORMATION

Street/ PO Box _____ City _____ State/Zip _____

Phone: Home _____ Work _____ Cell _____

EMPLOYMENT, INSURANCE & GENERAL HEALTH INFORMATION

Employer/ School _____ Occupation _____

Insurance Provider _____ ID _____ Group # _____

Previous Eye Doctor (Name/Town, State) _____ Last Visit ____/____/_____

Primary Physician (Name/Town, State) _____ Last Visit ____/____/_____

Do you Smoke? ☐ Yes ☐ No On average, how long are you 'on a screen' per day? _____ hours

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please list your medications (Rx, over-the-counter, daily vitamins/supplements): (1) _____ (2) _____
(3) _____ (4)_____ (5) _____(6) _____

REASON FOR TODAY'S VISIT

- ☐ Annual Exam
- ☐ Over Due for an Exam
- ☐ Not Seeing Well
- ☐ Damaged Glasses
- ☐ Want/Need New Glasses
- ☐ Contact Lens Update
- ☐ Interest in Contact Lenses

HAVE YOU PREVIOUSLY WORN PRESCRIPTION GLASSES OR CONTACT LENSES?

- ☐ No
- ☐ Yes, Glasses
- ☐ Yes, Contact Lenses

IF YES, WHAT FOR?

- ☐ Full-time
- ☐ Part-time
- ☐ Distance
- ☐ Near (reading)
- ☐ Computer

IF YOU WEAR CONTACT LENSES, WHAT KIND?

- ☐ Gas Permeable
- ☐ Daily Wear
- ☐ Overnight Wear
- ☐ Toric/ Astigmatism
- ☐ Soft
- ☐ Color
- ☐ MonoVision
- ☐ Bifocal/Progressive

CHECK ALL THAT APPLY: SELF/ FAMILY

SELF	FAMILY	
☐	☐	Allergies
☐	☐	Sinus Problems
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Heart Problems
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Thyroid Problems
☐	☐	Migraine Headaches
☐	☐	Head Injury
☐	☐	Head Surgery
☐	☐	Pregnant - # Mos. ___

SELF	FAMILY	
☐	☐	Blindness
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Macular Degeneration
☐	☐	Retinal Problems
☐	☐	Eye Disease
☐	☐	Eye Surgery
☐	☐	Eye Infection(s)
☐	☐	Eye Injury
☐	☐	Floaters
☐	☐	Lazy Eye
☐	☐	Vision Training

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

- ☐ Blurry Distance Vision
- ☐ Blurry Near Vision
- ☐ Frequent Headaches
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Watery Eyes
- ☐ Dry Eyes/ Burning
- ☐ Double Vision
- ☐ Color Blindness
- ☐ Night Blindness
- ☐ Light Sensitivity
- ☐ Glare Sensitivity

HOW DID YOU HEAR ABOUT US?

- ☐ Internet
- ☐ Insurance Plan
- ☐ Referral from Friend/Family

Let us know who _____

Payment Terms: Payment is due at the time of service. We accept multiple Insurance Providers. For a full list visit drdavidsobel.com/insurance. By signing this form I authorize payment of my medical benefits to Dr. David J. Sobel, O.D. LLC. I authorize Dr. David J. Sobel, O.D. LLC to release any information required to process my insurance claim. I understand that I am financially responsible for all non-covered services and materials.

Signature _____

Print Name _____

Date ___/___/_____