WELCOME To Franklin Eye Care! Please complete the following information for our records.

Name: ____ Preferred to be called: ________________________
Address:
____
P.O. Box: ____________
City: ____ State: ________________ Zip: ___________________
Phone: home: ___________________________________ work: ______________________________________
cell: ________________________________ e-mail: ____
Date of Birth: ____ Age: _______________
Do you work or are you retired? _____________________ Occupation: _________________________________
Where do you / did you work? _______________________________ Do you exercise? ____________________
Do you work on a computer? _________________________ How many hours per day_____________________
Referred by: ____
Relationship? ___________________________
When was your last eye exam? (approximately) ____
By Dr. ______________________________________ Office name: _____________________________________
Do you have any interest in wearing contacts? ____

Please complete the following health information so that the doctor may be aware of any factors that could impact your eye health:

Important: Please list all medications you take, including vitamins, supplements, over the counter, etc.:
____
____
____
____
____

YOUR General Health and Eye Health History (check all that apply):

____ allergies: ____
____ drug sensitivities: ____

____ diabetes	____ thyroid problems
____ high blood pressure	____ heart disease
____ seizures	____ cancer
____ back surgery	____ frequent headaches
____ eye injury	____ eye surgery
____ eye infection	____ light sensitivity
____ glaucoma	____ cataracts
____ double vision	____ lazy eye / amblyopia
____ floaters	____ flashes of light

____ other health issue or eye disease:
____

FAMILY (blood relatives) General Health and Eye Disease:
____ diabetes ____ thyroid problems
____ high blood pressure ____ heart disease

____ seizures ____ cancer
____ glaucoma ____ cataracts
____ macular degeneration ____ other eye disease

If you have worn contacts, please complete below:
Are you now wearing contacts? ____________ How old are your contacts lenses? _____________________
Do you see well with them (if no - explain)?
____
What do you use to clean them? ____________________ Do you ever sleep with them? ______________
Are your lenses comfortable? __________________ Do you have any dryness? ______________________
Please circle the type of lens you are wearing:

soft rigid gas permeable hard

disposable daily wear extended wear toric

Signature: ____________________________________ Date: ______________________

FRANKLIN EYE CARE, LLC
Dr. Paula A. McCurdy, Optometrist
2222 Delsea Drive, Franklinville, NJ 08322

My family doctor is:
____
Address:
____
Phone: __________________________________

My Pharmacy is:
____
Address:
____
Phone: __________________________________

Vision Insurance (if any)

____

I.D. # ______________________________

Health Insurance (if different)

____

I.D. # ______________________________

I request that payment be made either to me or on my behalf to Dr. Paula A. McCurdy, OD for services furnished to me by the provider. I authorize the provider to release to the appropriate insurance company / agency any information needed to determine these benefits or the benefits payable for related services.

Signature: ____

Date: ______________________