PATIENT HISTORY EVALUATION

Patient Full Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Race: ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander

Language: ☐ English ☐ Spanish Other _____

What is your communication preference: ☐ Mail ☐ Telephone ☐ Email ☐ Text

Would you like to receive order and appointment notifications via text: ☐ Yes ☐ No

Would you like to receive order and appointment notifications via email: ☐ Yes ☐ No

Social Security Number: _____ Birthdate: _____

Employer: _____ Occupation: _____

What brought you to Bard? ☐Website ☐TV ☐Radio ☐Social Media ☐Direct Mailer ☐Appointment Reminder
☐Doctor ☐Insurance Provider ☐Preferred Provider Program ☐Family Member

Primary Vision Insurance	Secondary Vision Insurance
Name of Insurance	Name of Insurance
Policy Holder Name	Policy Holder Name
Policy Number	Policy Number
Group Number	Group Number
Primary Medical Insurance	**Secondary Medical Insurance**
Name of Insurance	Name of Insurance
Policy Holder Name	Policy Holder Name
Policy Number	Policy Number
Group Number	Group Number
Policy Holder Information *(If you are covered under the policy of a spouse, partner, parent or guardian, please tell us about them)*	
Policy Holder Name	Relationship to Patient
Date of Birth	Social Security Number
Home phone	Home address
Mobile phone	
Work phone	
Employer	

Are you currently being treated for any other medical condition? ☐Yes ☐No If yes, what? _____
Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider:_____

Is there any possibility that you might be pregnant? ☐Yes ☐No ☐N/A

Today's Visit

Are you experiencing any of the following (without your glasses or contacts):

Blurred Distance Vision	☐Yes ☐No	Watering	☐Yes ☐No
Blurred Near Vision	☐Yes ☐No	Redness	☐Yes ☐No
Eyestrain	☐Yes ☐No	Burning	☐Yes ☐No
Double Vision	☐Yes ☐No	Sandy/Gritty/Dry Feeling	☐Yes ☐No
Headache	☐Yes ☐No	Night Vision Difficulty	☐Yes ☐No
Itching	☐Yes ☐No	Sensitivity to Sunlight or Bright Light	☐Yes ☐No

Is there any other reason for your visit today: _____

Patient or Parent/Guardian Signature: _____