LODESTAR
FAMILY EYE CARE, PC

JACOB FRANK, OD | KARA REYNOLDS, OD

GUIDING YOU TO BETTER VISION

Patient Name: _____ Date: _____

Address: _____ City: _____State: _____Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____
Preferred Method of Contact: ☐Cell Phone ☐ Home Phone ☐Email

Patient's Date of Birth: _____ Social Security Number: _____-____-_____

Occupation: _____ Name of Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse: _____

Please list any family members of your household who come to our office. _____

Who referred you to our office?
Insurance Listing ☐ Family Member ☐ Physician/Eye Doctor ☐Website ☐Facebook ☐ Passed by Office
☐ Previous Patient of Dr. Frank ☐ Dr. Reynolds ☐ Friend/Family Member – Name: _____

Special Visual Demands (work or hobbies): _____

Please check the box if you have ever had any of the following:
☐ Cataracts ☐ Glaucoma ☐ Lazy Eye ☐ Diabetes ☐ Macular Degeneration ☐ Eye Infections ☐ Dry Eye ☐ Migraines
☐ High Blood Pressure ☐ Allergies ☐Thyroid Disease ☐ Cancer ☐ Heart Disease ☐ High Cholesterol

Please list any other medical problems: _____

Who is your Primary Care Doctor? _____ Date of last exam/visit: _____

Have you ever smoked? _____ Do you currently smoke? _____ How often? _____

Do you drink alcohol? _____ How often? _____

Please list current medications and/or supplements:
_____

Are you allergic to any medications? ☐ Yes ☐ No Please List: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

Have any bloodline relatives had glaucoma, macular degeneration or other loss of sight? ☐ Yes ☐ No

Have you ever had any infection, injury or surgery (including LASIK) to your eyes? ☐ Yes ☐ No

Please describe: _____

Do you presently wear glasses? ☐ Yes ☐ No If yes, how old are the glasses? _____

When do you wear them? _____

Do you presently wear contact lenses? ☐ Yes ☐ No
☐ Soft Disposable ☐ Hard ☐ Gas Permeable ☐ Other

If yes, how old are the contacts? _____ If no, have you ever worn contact lenses? ☐ Yes ☐ No

Do you have vision care benefits? ☐ Yes ☐ No
If yes, what company and ID number: _____

Do you have medical health insurance? ☐ Yes ☐ No
If yes, what company name and ID number: _____

Primary Policy Holder Name: _____

Primary Policy Holder Date of Birth: _____ Primary Policy Holder Last 4 Social Security Number: _____

Patient Signature: _____