Welcome to **Blondin Shea Eyecare** *www.blondinsheaeye.com*

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Find us on: Facebook, Health Grades & Yelp

Patient Full Name: _____
Nombre completeo del paciente

Gender *Sexo* Male: _____ *Hombre* Female: _____ Mujer

Street Address: _____
Dirección de la calle

_____

City: _____ State: ____ Zipcode: _____
Ciudad *Estado* *Código Postal*

Home Phone: _____ Cell: _____
Teléfono de Casa *Teléfono Celular*

Date of Birth: _____ /_____ /_____
Día de nacimiento

Social Security Number: _____
Número de Seguro Social

Insurance Company: _____
Compañía aseguradora (Husky, Medicare, Blue Cross, Aetna, Connecticare, United Health Care, Etc.)

Insurance ID Number: _____
Número de identificación del seguro

Email Address: _____
Dirección del correo electrónico

Primary Care Doctor: _____
Médico de Atención Primaria

How did you hear about our practice? (New Patients Only)

___ Friend/Family ____ *Amigo / Familia*
___ Search engine/Website ____ *Motor de búsqueda / sitio web*
___ Social Media ____ *Medios de comunicación social*
___ Billboard ____ *Cartelera*
___ Other _____ ____ *Otro*_____

If patient is a minor, parent or legal guardian:
Si el paciente es menor de edad, el padre o tutor legal

Name :_____ Phone: _____
Nombre *Teléfono*

Attention: Please take note: By signing below I am indicating my understanding of this office's privacy practices which are available upon request. Also I give permission to the Doctors in the office to obtain data from my pharmacy electronically. I understand that if my primary insurance carrier does not pay all charges in full, I will be responsible for the remaining balance due to Blondin Shea Eyecare. If we cannot verify your insurance coverage, your appointment will be rescheduled. There is no refund on prescription eyewear. All prescription eyewear not picked up within 90 days of ordering will be donated to charity for those in need. Any patient who has not been present at time of a scheduled appointment on more then three occasions will be scheduled on a standby scheduled and may have an extended wait for appointments. (Traducción español disponible)

Signature: _____ Date: _____

Do you smoke cigerettes? □ *Yes* □ *No*
How many per day? _____
¿Fumas cigarrillos? ¿Cuántos por día?

Have you ever had any eye diseases or injuries? □ *Yes* □ *No*
Had tenido alguna enfermedad or accidente, Si o No?
*Please Describe:*_____
Por favor describa:

Does anyone in your family have glaucoma, cataracts or macular degeneration?
¿Alguien en su familia tiene glaucoma, cataratas o degeneración macular? Si o No? □ *Yes* □ *No*
*Who? ¿Quien?*_____

Are you pregnant? □ Yes □ No
Estás embarazada?

Do you take any prescription medicines?
Estas tomando algun tipo de medicina, Si o No? □ Yes □ No
Please list:_____
Por Favor Liste:
_____
_____

Health problems? _____
Problemas De Salud?
_____
_____

Are you allergic to any medicines?
Usted es Alergicos Algun Tipo de Medicina, Si o No?
□ Yes □ No _____

Do you wear….?

Glasses: □ Yes □ No Lentes, Si o No? **Contacts**: □ Yes □ No Contactos, Si o No?

When?¿Cuando?_____

In the last year, have you had any of these symptoms?
En el último año, ¿ha tenido alguno de estos síntomas?

___Fluctuation In vision ___ *Cambio de vision*
___Contact discomfort ___ *Descomformidad de contactos*
___Tired Eyes ___ *Ojos cansados*
___Burning ___ *Quemasón*
___Feeling of sand in eye ___ *Siente que tiene arena en los ojos*
___Light Sensitivity ___ Sensitividad en La luz
___Watery Eyes ___ *Lagrimas en sus ojos*
___Redness ___ *Ojos Rojos*
___Itching ___ *Picason*
___ Other _____ ___ *Otro*_____

Sírvase proporcionar: Altura: Peso:

Please provide: **Height: _____ Weight: _____**