UPTOWN EYES
EYEWEAR GALLERY
100 E. Joyce Blvd. 104
Fayetteville, AR 72703
P: 479.966.4232
Uptowneyesnwa.com

Welcome to our Office!

PATIENT INFORMATION

DATE: _____

NAME: _____

NICKNAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____

CELL PHONE: (_____)_____

EMAIL: _____

How would you like our office to communicate with you?

____ Email _____ Text _____ Phone

DATE of BIRTH: _____ AGE: _____

PATIENT'S SSN: _____

SEX: _____ MALE _____ FEMALE GENDER: _____

Preferred Language: _____
Preferred Pronouns:_____

Race:

- ○ American Indian or Alaska Native
- ○ Hawaiian / Other Pacific Islander
- ○ Black or African American
- ○ Asian
- ○ White
- ○ Other

Ethnicity:

○ Hispanic/Latino ○ Non-Hispanic/Latino

EMPLOYER OR SCHOOL: _____

OCCUPATION OR GRADE: _____

PCP Name: _____

Pharmacy: _____ Location:_____

REFERRAL INFORMATION

How did you hear about us?

- ○ Friend or Relative: Who? _____
- ○ Radio (NPR/KUAF): _____
- ○ Sign/Building _____
- ○ Social Media: _____ FB _____ Insta _____ Google+
- ○ Website
- ○ Insurance Listing _____
- ○ Event: _____
- ○ Other: _____

INSURANCE INFORMATION

Will you be using insurance for your visit? ○ YES ○ NO

*If using Insurance, please give the receptionist your medical and vision cards.

PATIENT MEDICAL HISTORY

CURRENT MEDICATIONS (Rx and OTC):

_____

_____

_____

ALLERGIES TO MEDICATIONS? ○ YES ○ NO

Please List:

_____

_____

Are you pregnant or nursing? YES NO

PATIENT EYE HISTORY

DATE OF LAST EYE EXAM: _____

PREVIOUS DOCTOR/CLINIC: _____

Do you currently wear contact lenses? _____ Yes _____ No

If so, What kind? _____

How often do you replace your lenses? _____

Do you sleep in your lenses? _____ Yes _____ No

Are you in need of new glasses? _____ Yes _____ No

SOCIAL HISTORY

Please Circle:

ALCOHOL? None / Rarely / Monthly / Weekly / Daily

TOBACCO? No / Smokeless / _____ packs per day/week

○ Never Smoker ○ Former Smoker ○ Current Smoker

FAMILY HISTORY

	Self	Family	Relationship to Patient:
Cancer	○	○	_____
Diabetes	○	○	_____
High Blood Pressure	○	○	_____
Heart Disease	○	○	_____
Kidney Disease	○	○	_____
Lupus	○	○	_____
Thyroid Disease	○	○	_____
Arthritis	○	○	_____
Blindness	○	○	_____
Cataracts	○	○	_____
Macular Degeneration	○	○	_____
Glaucoma	○	○	_____
Lazy Eye	○	○	_____
Double Vision	○	○	_____
Corneal Problems	○	○	_____
Dry Eye	○	○	_____
Floaters	○	○	_____
Eye Trauma/Injury			
Retinal Problems	○	○	_____
Other	○	○	_____

HOBBIES/INTERESTS

Please list your hobbies/interests:

_____