



metropolitan
EYECARE

Patient Name _____
First Middle Last

Age _____ Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone _____ E-mail _____

Occupation _____ Employer _____ Phone _____

Insured / Responsible Party's Name _____

Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Responsible Party's Date of Birth _____ Responsible Party's SS# _____

Vision Insurance _____ ID# (if applicable) _____

Has any member of your immediate family been a patient of Metropolitan Eyecare? If yes, please name.

To help our office keep more accurate records, please list any other family member living at home and their ages

How were you referred to our office? Yellow Pages Newspaper Sign Internet Direct Mail

Friend/relative _____ Company _____

Please check your method of payment. Cash Check Credit Card

Payment is expected at the time services are provided.

Lincoln Mall
260 A Lincoln Mall
Matteson, IL 60443
(708) 747-4800

Olympia Fields
3406 W. Vollmer Rd.
Olympia Fields, IL 60461
(708) 748-6016

St. John
9488 A. Wicker Ave.
St. John, IN 46373
(219) 365-7200

Manteno
170 S. Locust
Manteno, IL 60950
(815) 468-2525

Do you wear glasses now? Yes No

Do you have bifocals? Yes No

Do you have prism in your glasses? Yes No

Were you planning on purchasing glasses today? Yes No

Were you planning on purchasing contacts today? Yes No

Do you use a computer more than 30 minutes a day? Yes No

Are you interested in more information about contact lenses? Yes No

Please check any of the following that apply to you or family members:

	Self	Family Members		Self	Family Members
• Cataracts	_____	_____	• High blood pressure	_____	_____
• Glaucoma	_____	_____	• Heart disease	_____	_____
• Crossed eye	_____	_____	• Asthma	_____	_____
• Macular degeneration	_____	_____	• Sinus trouble	_____	_____
• Blindness	_____	_____	• Poor night vision or glare	_____	_____
• Eye infections	_____	_____	• Eyes burn, itch or tear	_____	_____
• Eye injury	_____	_____	• See spots or flashes	_____	_____
• Seasonal allergies	_____	_____	• Dry eyes	_____	_____
• Diabetes	_____	_____	• Double vision	_____	_____
• Eye surgery	_____	_____	• Headaches or eye pain	_____	_____
• Eye diseases	_____	_____	• Head injury	_____	_____
• Other _____	_____				

Approximate date of last eye exam: _____ Doctor: _____

Are you currently taking any prescription drugs, including birth control pills? Yes No

If yes, please describe _____

Have you ever had an allergic reaction to a drug? Yes No

Have you ever had an allergic reaction to penicillin? Yes No

Have you ever had an allergic reaction to anesthetic? Yes No

Have you previously worn contact lenses? Yes No

If yes, what type of lenses? Hard Gas Permeable Soft Daily Wear Flexible Wear

Extended Wear Disposable When did you last wear contact lenses? _____

Hobbies _____

Sports activities _____

Signed _____ Date _____