DENIS T. IWAMOTO, O.D.

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form.

PERSONAL INFORMATION:

Last Name: _____ First Name: _____ Sex: M / F
Nickname: _____ Date of Birth: _____ Last 4 SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone Number: _____ Secondary Phone Number: _____
Email Address: _____
Occupation: _____ Hobbies: _____
Hours of Electronic Usage Per Day (Estimate): _____
How did you hear about us?: _____

INSURANCE INFORMATION:

Person Responsible for Account: _____ Relation to Patient: _____
Date of Birth of Person Responsible: _____ Last 4 SSN of Person Responsible: _____
Name of Insurance: _____ Member's Employer: _____
ID#: _____

PATIENT VISUAL AND HEALTH INFORMATION:

What is the primary reason you have come in today?: ☐ Routine Exam ☐ Contact Lenses
☐ Blurred Vision ☐ Eye Strain ☐ Other: _____
When was your last eye exam?: _____ Doctor's Name: _____
Do you wear glasses now?: Y / N - If yes, how old are they?: _____
How are you currently seeing with your glasses?: _____
Do you wear contact lenses now?: Yes / No - If yes, what type?: Soft Lenses / Rigid Lenses

Any prior eye disease, injuries, surgery? Y / N - If yes, please explain: _____
Headaches? Y / N - If yes, please explain how often?: _____
Double Vision? Y / N - If yes, please explain when and how often?: _____
Any allergies? Y / N - If yes, please list: _____
Daily Medications? Y / N - If yes, please list: _____
For women, are you pregnant?: Y / N Nursing?: Y / N

FAMILY HISTORY:

Do you or anyone in your family have any of the following conditions? - If yes, who?
YES / NO - High Blood Pressure?: _____
YES / NO - Diabetes?: _____
YES / NO - Serum Cholesterol?: _____
YES / NO - Glaucoma?: _____
YES / NO - Cataracts?: _____
YES / NO - Macular Degeneration?: _____
YES / NO - Other eye-related condition(s)?: _____