CANYON
OPTOMETRY

Dr. Kirolos Fahmy | Dr. Chiara Delos Reyes
General Optometry | Ocular Disease | Keratoconus | Dry Eye

PATIENT INFORMATION:

Last Name:_____ First Name:_____ MI_____ DOB:_____

Address:_____ City:_____ State:_____ ZIP:_____

Occupation:_____ SSN(Last 4):_____ Cell Phone:_____

Email:_____Preferred Name/Nickname:_____

INSURANCE:

Vision (Comprehensive eye exams, eyewear, contact lenses): ☐ VSP ☐ MES ☐Other:_____

Medical (Urgent care visits – eye infections, injuries, diseases): ☐ HMO ☐ PPO Primary Carrier:_____

Secondary Carrier:_____

MEDICAL HISTORY: Please check if you have problems with any of the following systems:

☐ High Blood Pressure	☐ Respiratory	☐ Cardiovascular	☐ Gastrointestinal	☐ Ears/ nose/mouth/throat
☐ High Cholesterol	☐ Skin	☐ Neurological	☐ Psychiatric	☐ Endocrine
☐ Diabetes Type ____	☐ Urinary	☐ Muscles/Bones	☐ Blood/Lymph	☐ Allergic/Immunologic

☐ Other_____

Current Medications:_____

Allergies to Medications? YES/NO _____

Have you had any operations? YES/NO _____

Do you smoke? YES/NO

FAMILY HISTORY: Please check and list if any family members have been diagnosed with the following:

☐ Glaucoma:_____ ☐ Blindness:_____

☐ Macular Degeneration:_____ ☐ Other:_____

PERSONAL EYE INFORMATION: Check if you have been previously diagnosed with any of the following:

☐ Glaucoma	☐ Macular Degeneration	☐Cataracts	☐ Lazy eye / eye turn
☐ Dry Eyes	☐ Keratoconus	☐ Retinal Detachment	☐ Other_____

Have you had any eye operations? YES/NO _____

Have you had any eye injuries? YES/NO _____

Do you wear glasses? YES/NO Do you wear contact lenses? YES/NO Type?_____

Any Additional Information?_____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination and care. I understand that I am financially responsible for all charges, whether or not paid by insurance. Payment is due at the time services are rendered. I am aware that the *Notice of Privacy Practices* is available to view on the practice website, or a copy may be obtained from the office staff.

Patient Signature_____ Date_____