Choose a Locatior
Fishersville
Staunton
Waynesboro
Lexington

AUGUSTA EYE ASSOCIATES / EYEONE
RETINA CARE OF VIRGINIA

PATIENT INFORMATION (PLEASE PRINT) **REVISED 03/12**

(NAME) LAST	FIRST	MI	DATE OF BIRTH	MARITAL STATUS	SEX
				SINGLE ☐ WIDOWED ☐ MARRIED ☐ OTHER ☐	

STREET ADDRESS	CITY, STATE & ZIP CODE	HOME PHONE #
MAILING ADDRESS	CITY, STATE & ZIP CODE	CELL PHONE #

SOCIAL SECURITY #	☐ DISABLED ☐ RETIRED	EMPLOYER	PHONE #

RACE	LANGUAGE	ETHNICITY
☐ AFRICAN AMERICAN	☐ ENGLISH	
☐ CAUCASIAN	☐ SPANISH	☐ HISPANIC OR LATINO
☐ HISPANIC	☐ MUTE/DEAF	☐ NOT HISPANIC OR LATINO
☐ KOREAN	☐ OTHER	☐ OTHER
☐ MULTIRACIAL	☐ UNKNOWN/NOT REPORTED	☐ UNKNOWN/NOT REPORTED
☐ OTHER		
☐ UNKNOWN/NOT REPORTED		

EMAIL	PRIMARY CARE PRACTITIONER

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE #

IF PATIENT IS A MINOR (GUARANTOR INFORMATION)

LAST	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY #

STREET ADDRESS, CITY, STATE, & ZIP CODE	HOME PHONE #
EMPLOYER	WORK PHONE #

IF POLICY HOLDER IS OTHER THAN PATIENT, PLEASE COMPLETE

POLICY HOLDER _____ MALE ☐ FEMALE ☐
SOCIAL SECURITY # _____
DATE OF BIRTH _____
EMPLOYER _____

EyeOne / RetinaCare of Virginia

Patient Name _____Date of Birth____/ ____ /____Date _____

Medications (if unable to complete staff will assist you)
(Attach list or list any medications that you now take.)

Eye Medications	**Other Medications**

Allergies ☐ NONE

List Allergies	**Reaction (Ex: Rash)**

Past Eye History – Have you ever experienced any of these eye conditions? Please circle all that apply.

Cataract ☐

Cornea/Conjunctiva problem ☐

Glaucoma ☐

Refractive Surgery/LASIK ☐

Neurological eye problem ☐

Plastic Surgery around eyes ☐

Retina: Tears Detachment ☐

Eye Turning In or Out ☐

Medical History

List any medical conditions for which you have been treated:

Surgical History

List surgery and date of surgery.

Family History Please circle all condition(s) that occur in your family.

		RELATIONSHIP
Blindness	☐	
Cataracts	☐	
Glaucoma	☐	
Macular Degeneration	☐	
Retinal Disorders	☐	
High Blood Pressure	☐	
Diabetes	☐	
Heart Disease	☐	

Social History

Are you a:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Smoker, current status unknown
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol use? ☐ Yes ☐ No ☐ Formerly

Blood Sugar (If known)

Blood Sugar _____ A1C _____
Date Taken _____

Tech Review _____Date_____ Tech Review _____Date_____

Additional Insurance Information

Insurance Name _____

Insurance Phone # _____

Member ID # _____

Name of Vision Coverage (if known) _____

Group # _____

Subscriber Name _____

Subscriber SSN _____

Subscriber DOB _____

Submit Form