Welcome To Our Office | Family Eyecare of Roswell | Maurice E. Zadeh, Optometrist & Associates

To help us better serve you, we ask that you please fill in the information requested below. Thank you.

Patient Demographic Information: (Required Fields)

Name: _____ **Gender:** M F
Last First MI Preferred

Primary Language: _____ **DOB:** _____ _____
Month / Day / Year Age

Race: _____ **Ethnicity:** _____

Patient's Medical History: (Required Fields)

Yes		Any immediate family members with conditions:
□	Glaucoma	
□	Cataracts	
□	Eye Injuries	
□	Eye Surgery	
□	Dry Eyes / Watery Eyes	
□	Amblyopia (Lazy Eye)	
□	Strabismus (Crossed Eyes)	
□	Color Vision Problems	
□	Sinus Problems	
□	Diabetes	
□	High Blood Pressure	
□	Seasonal Allergies	
□	Drug Allergies	
□	Thyroid Problems	

Please list ALL current medications:

- □ Do you have headaches?
- □ Are you light sensitive?
- □ Do you wear sunglasses?
- □ Do you use a computer or other electronics? If yes, how many hours do you spend in front of a screen daily? _____
- □ Do you use tobacco?
- □ Do you consume alcohol on a frequent basis?
- □ Do you use other substances?

Patient Contact Information: (Required Fields)

Address: _____
Street APT

_____
City State Zip

Referred by: _____
Insurance / Patient / Doctor / Website / Google / FB

PCP: _____ ( )
Physician or Practice Name Phone

Pharmacy: _____
Name / Address

Emergency Contact: _____
Name

Preferred Method of Contact:

Email / Work / Cell - Is Texting okay? □

Email: _____
Recall & Office Communications

Cell: ( )

Work: ( )

Employer: _____

( )
Phone Number

( )
Phone Number

_____ _____
Patient Name (Print) **Patient Signature / Guardian Signature (under 18)**