New Patient Form

First name _____ Last name _____

Physical address _____

City _____ State _____ Zip _____

Email _____ Phone _____

Emergency Contact _____

Emergency Contact Phone _____ Relationship _____

Check the conditions that apply to you:

☐ Asthma	☐ Cancer	☐ Mental Health Disorders
☐ Cardiac Disease	☐ Diabetes	☐ Glaucoma
☐ Hypertension	☐ Epilepsy	☐ Other

If you chose "Other" please describe: _____

_____

List any health or eye conditions of immediate relatives: _____

_____

Please list any medications and supplements you are currently taking: _____

_____

Do you have any medication allergies? ☐ Yes ☐ No ☐ Not Sure

If yes, what medication(s) are you allergic to? _____

What is the reason for today's visit? _____

_____

Signature _____