Columbia Falls Eyecare
211 5th Street West
Columbia Falls, MT 59912
T: (406) 892-4140
F: (406) 892-4146

PATIENT INFORMATION

Last: _____ First: _____
Date of Birth: _____ Age: _____ Sex: M F
Mailing Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Preferred Communication Method (Please Circle One)
Phone Call Text Message Email Mail
SSN: _____
Employer: _____
Spouse's Name (if applicable): _____
Parent/Guardian's Name (if a minor): _____

Primary Medical Insurance

Insurance Company: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber Member ID#: _____

Secondary Medical Insurance

Insurance Company: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber Member ID#: _____

VISION INSURANCE

Insurance Company: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber Member ID#: _____

EYEWEAR HISTORY

Do you currently wear prescription glasses? **Y N**
If Yes, do you wear them: **Full-time Part-time**

Are you planning on purchasing a new frame today?
Y N

Do you currently wear Contact Lenses? **Y N**
If Yes, do you wear them: **Full-time Part-time**

Do you need your contact lens prescription renewed today? **Y N**

Are you planning on purchasing contact lenses today?
Y N

PERSONAL MEDICAL HISTORY

What is the name of your primary care practice/physician?_____
_____
Date of last physical: _____

Are you allergic to any medications? **Y N**
If yes, which one(s): _____
_____

Have you had any previous eye injuries/surgeries? **Y N**
If yes, please explain: _____
_____

Have you been diagnosed with:

	Y	N		Y	N
Glaucoma			Cataract		
Macular Degeneration			Hypertension		
Diabetes			High Cholesterol		

Have any immediate family members (parent, grandparent or sibling) been diagnosed with:
Glaucoma Macular Degeneration Diabetes
If yes, who? _____

Do you currently: **Smoke Use Smokeless Tobacco Use Electronic Cigarettes**
If not, have you previously? **Y N**
If yes, when did you approximately quit: _____

Do you have any of the following medical issues?

	Y	N		Y	N
Ears			Allergies		
Nose			Skin		
Mouth			Auto-Immune System		
Throat			Neurologic System		
Heart			Thyroid		
Lungs			Back		
Endocrine System			Neck		