## Welcome to Radiant Family Eyecare Adult Form (Please Print)

Date/	Social Security #	
Name	Gender: M F Date of Birth///	
Address	***Referred by	
City State Zip	Spouse Name	
Home phone (	Spouse Social Security #	
Work phone (	Spouse Date of Birth//	
Cell phone (	Spouse Work phone ()	
Employer	Spouse Cell phone ()	
Occupation	Spouse's Employer	
E-mail Address	Emergency Contact	
Date of last eye exam	Phone # ()	
Who performed last eye exam?	Relationship	
Are you diagnosed as Diabetic/Pre-diabetic? Yes No		pe 2
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	Information	اء ۔
Vision Insurance Primary Member	To better serve you, all insurance claims will be processe immediately with the insurance information provided at	
Medical Insurance	time of the appointment.	<del></del>
Primary Member		
AUTHORIZATION TO RELEASE INFORMATION TO YOU	R INSURANCE COMPANY AND ACKNOWLEDGEMENT OF	
PERSONAL RESPONS	NOU ITY FOR RAYMENT	
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Personal and Family Medical History					
	<b>N</b> 1/A	0.167.1	5 11 B. 11 11		
Ear/Nose/Throat:	N/A	Self (please list condition)	Family Relationship		
Hay Fever					
Sinus Congestion Other					
Cardiovascular:					
Heart Disease					
High Blood pressure					
High Cholesterol					
Other					
Respiratory:					
Asthma					
Other					
Gastrointestinal					
Irritable Bowel					
Other	H	<b>—</b>			
Genitourinary:					
Kidney Problems					
Other					
Musculoskeletal:					
Arthritis					
Other					
Integumentary:					
Skin Disorder					
Neurological:					
Headaches					
Migraines					
Seizures					
Stroke					
Other					
Psychiatric:					
Anxiety					
Depression					
Alzheimer's/Dementia					
ADD/ADHD					
Other					
Endocrine:					
Diabetes					
Thyroid Disease					
Other					
Lymphatic:					
Anemia					
Bleeding Problems					
Other					
Allergies:					
Seasonal					
Other	Ħ				
General:					
Cancer (type and date Dx)					
Other	H				
Reviewed: Date:		Patient Initials:	Doctor:		
Date:		Patient Initials:	_Doctor:		
Date:			_Doctor:		
Date:		_ Patient Initials:	_Doctor:		