WESTWOOD & MONTROSE EYE CENTER

Westwood: (310) 234-8900 | Glendale: (818) 330-7555

NEW PATIENT INTAKE FORM

Patient Information

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ M ☐ F ☐ Other

Home Address (Street, City, State, Zip): _____

Cell Phone: _____ **Email Address:** _____

Occupation: _____ **Emergency Contact & Phone:** _____

Insurance Information

Vision Insurance (e.g., VSP, EyeMed): _____ **Member ID #:** _____

Primary Medical Insurance: _____ **Member ID #:** _____

Primary Subscriber Name (If not patient): _____ **Subscriber DOB:** _____

Medical & Ocular History

Reason for today's visit: _____

Please check any conditions that apply to YOU or your FAMILY (blood relatives):

Condition	Self	Family	Condition	Self	Family
Glaucoma	☐	☐	High Blood Pressure	☐	☐
Macular Degeneration	☐	☐	Heart Disease	☐	☐
Cataracts	☐	☐	Diabetes	☐	☐
Retinal Detachment	☐	☐	Autoimmune (Lupus, RA, etc.)	☐	☐
Dry Eye / Blepharitis	☐	☐	Thyroid Condition	☐	☐

List any past eye surgeries (LASIK, Cataract, etc.) and approximate dates:

_____

_____

List any current medications (or attach a list):

Drug Allergies: _____

Visual Lifestyle

Hours per day on a computer/phone? ☐ 0-2 ☐ 2-4 ☐ 4-8 ☐ 8+

Do you wear Contact Lenses? ☐ No ☐ Yes, Soft ☐ Yes, Hard/RGP

Hobbies / Visual Demands (e.g., Golf, Sewing, Night Driving): _____

Signature & Acknowledgment

I certify that the information provided above is complete and accurate to the best of my knowledge. I authorize Westwood & Montrose Eye Center to bill my insurance on my behalf, and I understand that I am financially responsible for any balance not covered by my insurance carrier.

_____ _____

Patient (or Guardian) Signature **Date**