



# Eye Consultants OF PENNSYLVANIA, PC

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**Pottstown Office**

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**Blandon Office**

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**Lebanon Office**

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Lebanon, PA 17042  
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[E-mail:ecop@ecop.us](mailto:ecop@ecop.us)

## New Patient Information Form

**Please complete this form as clearly and completely as possible, and Bring It With You at the time of your appointment. PLEASE PRINT! This form will allow us to expedite your appointment. Thank you for your cooperation.**

(Mr., Mrs., Miss, Ms.)

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Telephone: Home( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Occupation \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Doctor	Name	Address
Referring Doctor		
Family Doctor		
Optometrist		

**If the patient is a child, list name and address of the person financially responsible for the child's account below:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Social History:**

Do you drive? Y / N Do you use illegal drugs? Y / N  
Do you smoke? Y / N How much? \_\_\_\_\_ How long? \_\_\_\_\_ Date stopped: \_\_\_\_\_  
Do you drink? Y / N How much? \_\_\_\_\_

**Eye Problems:**

Cataracts: Y / N Corneal problems, dry eye: Y / N  
Glaucoma: Y / N Eye injury: Y / N Describe: \_\_\_\_\_  
Retinal disorders: Y / N Eye Surgery: Y / N What type? \_\_\_\_\_ When? \_\_\_\_\_  
Do you wear glasses/contacts? Y / N Prescribed by: \_\_\_\_\_ When? \_\_\_\_\_

(over)

