Baker Eye Care
1700 N Stephenson Ave
Iron Mountain, MI 49801
P:906-774-6288 F:906-774-6295
bakereyecare2020@gmail.com

Welcome To Our Office

Welcome to Baker Eye Care! We are delighted to serve you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Date: _____

Name: _____ Date of Birth: _____Age: _____

Address: _____

City, State, Zip: _____

Cell phone: _____Home number: _____ Work: _____

Person of Emergency: _____ Number: _____

Employer/School: _____Occupation/Grade School: _____

Social Security Number: _____

Email Address: _____

Preferred method of contact: call text email postcard

Primary Care Physician

Physician Name: _____

Date of Last Eye Exam _____ Do you wear glasses____ Contacts____

Main reason for exam today _____

Health History

Patient's Eye History:

Glaucoma	Y/N
Cataracts	Y/N
Macular Degeneration	Y/N
Floaters/Flashes of light	Y/N
Dry/Watery	Y/N
Itchy/Gritty	Y/N

Other_____

Does the patient have any of the following conditions and take medications for it:

Diabetes	Y/N
Heart Disease	Y/N
High Blood Pressure/Hypertension	Y/N
High Cholesterol	Y/N
Asthma	Y/N
Other _____	

Current Medications:

_____
_____
_____
_____

Allergies to Medications:

_____
_____
_____

Family Health History:

Glaucoma	Y/N	Macular Degeneration	Y/N
Cataracts	Y/N	Retinal Detachment	Y/N
Diabetes	Y/N	High Blood Pressure	Y/N
High Cholesterol	Y/N		
Other_____			

** I authorize Baker Eye Care/Dane Baker OD PC to release my medical records, health information, and billing information to the person(s) listed below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Print name: _____ **Signature: _____**

Date signed: _____