SAN GABRIEL VALLEY EYE INSTITUTE

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# New Patient Intake Form

Thank you for choosing us. Please fill this out before your visit so we can spend more time on your care.
Type into the boxes on a computer or phone, or print it and write by hand.

**Full name**

**Date of birth (MM/DD/YYYY)**

**Phone**

**Email**

**Primary care doctor**

**Referring doctor or optometrist (if any)**

**What is the reason for your visit?**

**Your eye history (diagnoses, surgeries, lasers, injections)**

**Family members with eye disease (for example glaucoma or macular degeneration)**

**Your medical history (major conditions, diagnoses, surgeries)**

**Current eye drops (name and how often)**

**Current medications (name and dose)**

**Allergies to medications or anything else**

**Preferred pharmacy (name and city)**

**Today's date**