Welcome to Our Office

Date _____

Patient's Name _____ Sex: ☐ F ☐ M Age _____ Date of Birth _____
Please circle one: Mr. Mrs. Miss Ms.

Address _____
Street City State Zip

Telephone (Home) _____ (Work) _____ Best time to be contacted _____

Social Sec. Number _____ Parent's Name _____ Spouse's Name _____
(If patient is a minor)

If Student, Grade ____ School _____ Occupation _____ Phone (Cell) _____

Employer _____ Address _____

Responsible party for account _____ Email Address _____

Payment Preference Cash ___ VISA/MC ___ Other _____

Do you have insurance? ☐ Yes ☐ No If Yes, list insurance provider _____

Insured's name _____ Insured's date of birth _____ Insured's employer _____

Insured's identification # _____ Group # _____ Member services phone # _____

Approximate date of last eye examination _____ By Doctor _____

GENERAL HEALTH (past or present)

___ eye diseases ___ diabetes ___ drug sensitivities

___ headaches ___ high blood pressure ___ seizures

___ eye or head injuries ___ heart disease ___ skin conditions

___ glaucoma ___ allergies ___ tuberculosis (TB)

FAMILY HISTORY (blood relatives who have)

___ diabetes ___ glaucoma ___ high blood pressure

___ heart disease ___ cataracts

___ eye diseases ___ blindness

Family Physician _____ Address _____

Are you presently being treated for any medical conditions? _____

If so, what conditions? _____

Last general health exam (date) _____

Are you presently taking any medications? (including hormones or birth control pills) _____

Please list present medications _____

_____

Do you feel your vision problems occur at distance? _____ near? _____

Do you experience eye strain or dry eye symptoms such as: _____ burning ____ twitching eye lids ____ gritty eye feeling

_____ itching ____ light sensitivity ____ painful or sore eye

Do you use eyedrops? _____ yes _____ no _____ tearing ____ light glare ____ blurred vision

Are you interested in learning if you are a good candidate for Laser Vision Correction? ☐ **YES** ☐ **NO**

Would you like to wear contact lenses? _____ Have you ever worn contact lenses? _____

If so, when were they prescribed? _____ Where do you purchase your contact lenses? _____

Do you remove your contact lenses at night? ☐ **YES** ☐ **NO** What brand of contact lenses do you wear? _____

Have you ever tried vision training or eye exercises? _____

Who may we thank for referring you to this office? _____