

Welcome to Our Office

Please provide the following information as completely as possible.

(Please Print)

All information will be kept strictly confidential

.....
Date _____ Social Security # _____
Full Name _____ Referred by _____
Address _____ Date of Birth _____
City _____ State _____ Zip _____ Employer _____
Home PH _____ Work PH _____ Spouse's Name _____
E-Mail Address _____
Please List any family members who are patients _____
What is your primary reason(s) for this office visit? _____

Please check any of the following problems you have with your eyes.
__ Blurred Vision at Distance __ Pain around the Eyes __ Flashes of Light
__ Blurred Vision at Near __ Eyestrain __ Floaters
__ Double Vision __ Dry Eyes

Please check if you have had any of the following:
__ Eye Disease __ Eye Surgery
__ Eye Injury __ Head Injury

Are you bothered by headaches? () Yes () No
If so, how often do they occur? _____

Approximate date of last exam _____ by Doctor _____

If you wear glasses or contact lenses, how old are they?
Glasses- _____ years Contacts- _____ years
Are you interested in wearing contact lenses? () Yes () No

Please check if you or any of your immediate family have a history of the following:
High Blood Pressure () you () relative- _____
Diabetes () you () relative- _____
Heart Condition () you () relative- _____
Cataracts () you () relative- _____
Glaucoma () you () relative- _____
Macular Degeneration () you () relative- _____
Crossed Eyes () you () relative- _____
Loss of Vision () you () relative- _____

Are you currently being treated for any serious medical condition(s)? () Yes () No
If yes, please specify _____

Date of last complete physical _____ by Doctor _____

List any medication you are taking-including birth control pills.
1. _____ 2. _____ 3. _____ 4. _____
List any medications to which you are allergic.
1. _____ 2. _____ 3. _____ 4. _____

Responsible Party: () Self () Vision Insurance () Other _____
Preferred Method of Payment: () Cash () Check () Visa () Master Card () American Express () Discover

I understand that I am responsible for any outstanding balance including any amount not paid by my insurance.

Signature _____ **Date** _____

In case of emergency contact: _____ Phone Number: _____