WELCOME TO OUR OFFICE

Last Name	First Name	Date	Social Security # (Optional)

Address	City	State	Zip

Home Phone	Business Phone	Cell Phone	E-mail Address

Employer	Occupation	Birth Date	Age	Sex M☐ F☐

Insurance: Type and I.D.	Primary Insured

Form of Payment: Cash Check Credit Card	Date of the last examination

Whom may we thank for referring you?

Reason for your office visit today: (Check all that apply)

- ☐ Lost or broken eyeglasses
- ☐ Want new glasses
- ☐ Want new contact lenses
  - ☐ Soft
  - ☐ Hard
  - ☐ Colored
  - ☐ Disposable
- ☐ Yearly eye exam
- ☐ Problems with current contact lenses
- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Problems with night driving
- ☐ Eyes water
- ☐ Eyes Itch
- ☐ Eyes feel dry
- ☐ Pain in eyes
- ☐ Headaches
- ☐ Eyestrain
- ☐ Droopy eyelid
- ☐ Eyes burning
- ☐ Eyes feel tired
- ☐ "Spots" or floaters/flashes
- ☐ Double Vision
- ☐ Sensitive to light
- ☐ Other _____

Personal Medical History: (Check all that apply to YOU)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart disease
- ☐ Arthritis
- ☐ Age Related Macular Degeneration
- ☐ Cancer
- ☐ Stroke
- ☐ Thyroid
- ☐ HIV/AIDS
- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ "Lazy Eye"
- ☐ Refractive Surgery
- ☐ Eye Surgery
- ☐ Eye Injuries
- ☐ Retinal Problems
- ☐ Blood Transfusion?
- ☐ Other _____

Family Medical History: (Check all that apply to immediate family members)

- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Diabetes
- ☐ Age Related Macular Degeneration
- ☐ Cancer
- ☐ Stroke
- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal Disorders

Social History:

- ☐ Do you smoke? No Yes 1-5 per day 1 pack/day more
- ☐ Do you drink? No Yes 1 per day 2-3/week more

Current Medications:

_____

_____

List activities in which you participate:

Computers: How many hours per day? _____

Sports: _____

Hobbies: _____

Are you pregnant: Yes No

If yes, months: _____

Allergies to medications: Yes No

If yes, which ones:

_____

_____

_____

Allergies to contact lens solutions: Yes No

If yes, which ones:

_____

_____

_____

"While we will make every effort to verify and confirm your insurance, it is your responsibility to understand the terms and conditions of your insurance. Payment for co-pays and non-insured services are expected at the time of service. Thank you for allowing us to serve your eye care needs"

Patient Signature/Legal Guardian _____