WELCOME TO OUR OFFICE

For faster service, please complete the following form prior to arriving at our office.

Date\_\_\_/\_\_\_/\_\_\_\_\_\_

Patient’s Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_\_\_ M or F

Date of last exam \_\_\_\_\_\_\_\_\_\_\_\_\_Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_ Zip Code \_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emer. Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If child, parent’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit or eye problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you considering purchasing (circle all that apply) Eyeglasses Sunglasses Contact lenses

Laser Corrective Surgery

Personal Medical Information:

Do you have: (Please circle) Diabetes High Blood Pressure Headaches Glaucoma

Macular Degeneration Cataracts Retinal Detachment

Any allergic reactions to medications or other substances? Yes No List them\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of general physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take medications? Yes No Please list names & how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have family history of any of the following? If Yes, please circle

Diabetes Glaucoma High blood pressure Macular Degeneration Retinal Detachment Cataracts

Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following? If Yes, please circle. Dry Eyes Eye Surgeries Wear Glasses Blurred Vision Eye Injuries Wear Contacts Itchy Eyes

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge. Payment is due at the time services are rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I have been given a copy of the Notice of Privacy Practices.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_