

WELCOME TO OUR OFFICE

PATIENT INFORMATION (Please Print)

DATE _____

Mr. ___ Mrs. ___ Ms. ___ Name _____ Male ___ Female ___

Address _____ City/State _____ Zip _____

Ph #: Home _____ Work _____ Cell _____

SS# _____ Date of Birth _____ Age _____ Occupation _____

Employer/School _____ Email _____

How did you hear about our office? ___ Yellow pages ___ Newspaper ___ Insurance ___ Other _____

List activities/hobbies that may require special vision care _____

Are you wearing contact lenses? ___ Yes ___ No Would you be interested in a trial pair (must have a contact fitting)? ___ Yes ___ No

INSURANCE INFORMATION

Insurance Company _____ Subscriber ID # _____

Subscriber _____ Subscriber DOB _____ SS# _____

Subscriber Employer _____ Grp # _____ Plan# _____

Relationship to Subscriber ___ Self ___ Spouse(name) _____ ___ Child ___ Other _____

Does your plan cover Routine Vision? ___ Yes ___ No If no, which carrier does? _____

Supplemental Insurance _____ Subscriber ID# _____

HAVE YOU HAD:	Yourself	If so, how long?	Family Member	Relationship
Glaucoma	_____	_____	_____	_____
Cataract	_____	_____	_____	_____
Lazy Eye	_____	_____	_____	_____
Allergy	_____	_____	_____	_____
Blindness	_____	_____	_____	_____
Floaters/Flashes.....	_____	_____	_____	_____
Double Vision	_____	_____	_____	_____
Halos around lights.....	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Respiratory Condition.....	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Thyroid	_____	_____	_____	_____
Other	_____	_____	_____	_____
.....	_____	_____	_____	_____

Do you smoke? _____ How much? _____ Use alcohol beverages? _____ How much? _____

List any current medications? _____

List any allergies (medications or other) _____

Primary Care Doctor _____ Ph# _____ Last Physical exam _____

Previous Eye Doctor _____ Last Eye Exam _____

Reason For visit today _____