

PATIENT INFORMATION

Name _____
Last First Middle

MR. Soc. Sec. # _____
 MRS. _____
 MS. Work Phone _____

Address _____ Birth Date _____

City _____ State _____ Zip _____ Male Female

Single Married Other

Home Phone _____ E-Mail # _____ Employed Part Time Student Full Time Student

If you have insurance coverage - please fill out this area.

Primary Insurance Company _____ Group # _____ ID. # _____ Vision
 Medical

Relationship to Insured: Self Spouse Child Other

Secondary Insurance Company _____ Group # _____ ID. # _____ Vision
 Medical

Relationship to Insured: Self Spouse Child Other

Family Members Living at Home:

Spouse _____ Age _____ Husband Wife

Name _____ Age _____ Son Daughter Other

Name _____ Age _____ Son Daughter Other

- Please answer the following questions to aid us in giving you a complete and comprehensive examination.
 Thank you for your cooperation.
1. Any difficulty seeing at a distance? Yes No Approximately how long? _____
 Night Vision Driving T.V. Movies Other _____
 2. Any problems focusing clearly at close range? Yes No Approximately how long? _____
 Reading Sewing Phone Book Work Other _____
 3. Do your eyes: Burn Ache Tire Itch Water
 4. Sensitive to light? Yes No Flourescent Lights Glare Night Driving Snow Sun
 5. Do you wear glasses? Sunglasses Sport Work Dress Other _____
 6. Hobbies _____
 7. Do you work with a computer? Yes No at Work Home
 8. Have you ever worn contact lenses? Yes No Type? Soft Other _____
 Currently wearing contact lenses? Yes No Type? Soft Other _____
 Interested in learning more about the benefits of contacts? Yes No
 9. Do you have any family history of the following items:
 Allergies Sinus Problems Diabetes _____
 High Blood Pressure Cataracts Glaucoma _____
 10. Headaches? Yes No How Often? _____ Do you have? Double Vision Spots
 11. Family Physician _____ Dentist _____
 12. Medications currently taking _____

Payment method: Cash _____ Check _____ Credit Card _____ Insurance _____

Signature of Party Responsible for Payment _____ Date _____ Relationship _____

FOR OFFICE USE ONLY

Doctor _____ Recall Date for Exam _____ Date 2 (Secondary Recall Date _____)

Last Visit Date _____ Service Date _____ Glaucoma Check

Last Exam Date _____ Date 1 (Date of First Visit) _____ Cataract Check

Contact Lens Check

Visual Field Test

Other