

# Welcome to our Office!

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Home telephone \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Work telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Can we leave message at work? Yes / No

Date of Birth: \_\_\_\_\_

Sex: M / F

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: S / M / D / W

E-mail: \_\_\_\_\_

Name of responsible person or spouse: \_\_\_\_\_ Relationship: \_\_\_\_\_

Their address (if different from above): \_\_\_\_\_ Their telephone (if different from above): \_\_\_\_\_

Patient (or Father's) Employer: \_\_\_\_\_ City: \_\_\_\_\_ Telephone: \_\_\_\_\_

Spouse (or Mother's) Employer: \_\_\_\_\_ City: \_\_\_\_\_ Telephone: \_\_\_\_\_

**INSURANCE:**

Primary Medical Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Policy Holder D.O.B. \_\_\_/\_\_\_/\_\_\_

Secondary Medical Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Policy Holder D.O.B. \_\_\_/\_\_\_/\_\_\_

Do you or your spouse have a flexible spending plan or cafeteria plan through an employer? yes or no (circle)

Do you have any special vision insurance plan or benefits? Please list: \_\_\_\_\_

Who is your primary physician? \_\_\_\_\_ Pharmacy? \_\_\_\_\_

Referred by: (circle) Yellow Pages / Office Sign / Newsletter / Here Before / Insurance / Other /

Friend or Relative: (list) \_\_\_\_\_

Jobs, Hobbies or Visual Activities: (circle) Reading / Computer / Golf / Home Workshop / TV / Fishing / Hunting / Sewing

Gardening / Outside Activities / Swimming / Team Sports / Other: \_\_\_\_\_

Do you have any special lens interests? (circle) Sunglasses / Sport Glasses / Safety Glasses / Computer Glasses

Have you ever worn contacts before? \_\_\_\_\_

I am interested in: (circle) Lasik / CRT / Contact Lenses / Contact Lens Test Drive / None of the previous

Do your eyes: (circle) itch / burn / sting / water / ache / feel gritty / get red / other: \_\_\_\_\_

Are you bothered by: (circle) light glare / sunlight / headlights / dim light conditions / other: \_\_\_\_\_

Are you having specific difficulty with your vision? \_\_\_\_\_

Please list current eye medications? \_\_\_\_\_

Please list your prescription and non-prescription pills, ointments, medications, etc.: \_\_\_\_\_

Please list any medication allergies or sensitivities: \_\_\_\_\_

Personal social history: (circle) smoke / chew tobacco / alcohol

Personal eye history: (circle) injuries / diseases / surgeries / congenital defects Explain: \_\_\_\_\_

Family eye history: (circle) cataracts / glaucoma / macular degeneration / lazy eye / color blind / retinal detachment /

other (list): \_\_\_\_\_

Patient and Family Medical History: Have you or any of your blood relatives ever had: (circle)

Allergies:	me	relatives	Constitutional:	me	relatives	Heart Disease:	me	relatives
Stomach/Digestive:	me	relatives	Kidney-Bladder:	me	relatives	Ear/Nose/Throat:	me	relatives
Respiratory:	me	relatives	Blood-Lymph:	me	relatives	Muscle/Joint/Bone:	me	relatives
Cancer:	me	relatives	Strokes/Seizures:	me	relatives	Other Neurological:	me	relatives
Psychological:	me	relatives	High Blood Pressure:	me	relatives	Skin Diseases:	me	relatives
Thyroid-Pituitary:	me	relatives	Ovarian/Uterine:	me	relatives	Breast Disease:	me	relatives
Prostate	me	relatives	Diabetes:	me	relatives	Other:	_____	

*We ask that payment be made on the day of the service, unless prior arrangements have been made. We accept Master card, Visa and Discover. We will submit insurance for you. I understand this policy as it is described, and accept responsibility for this account:*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_