

Time of arrival _____

Welcome to our office

(please print)

Patient's name Miss Ms. Mrs. Mr. _____

Date of Birth _____ Age _____ SSN#xxx-xx-_____

If Child, name of Parent or Guardian _____

Home phone _____ Daytime phone _____ Cell phone _____ Ok to text? Yes No

Email _____ Ok to email? Yes No

Home Address _____

City _____ Zip _____

No change to address
(please initial) ____

Primary vision insurance _____ Primary health insurance _____

Occupation _____ Employed by _____

Business Address _____ Business phone _____

If married, name of spouse Miss Ms. Mrs. Mr. _____

Spouse's Date of Birth _____ Spouse's Age _____ Spouse's SSN#xxx-xx-_____

Spouse's Occupation _____ Spouse employed by _____

Spouse Business Address _____

Spouse's Cell phone _____ Spouse's Email _____

How did you find out about our office? (please circle if applicable)



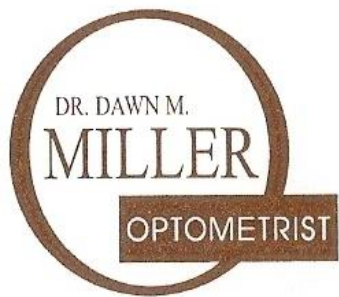
Friends/family: _____ Other: _____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. At least 50% deposit is required on all orders with the balance due on delivery. If your visit is covered by any type of private or union insurance, the office will be happy to complete the necessary insurance forms at a fee of \$5.00. However, payment is expected from the patient as stated above with reimbursement from the insurance company going directly to the patient.

Signed _____

Date _____

Please flip over & fill out both sides...



Please help us verify yearly...

Patient's name Miss Ms. Mrs. Mr. _____ Date _____

Are you or anyone in your family currently being treated for or have a history of.....? (please circle)

Glaucoma	self	family	Diabetes	self	family
Cataracts	self	family	High Blood Pressure	self	family
Macular Degeneration	self	family	High Cholesterol	self	family
Crossed eyes	self	family	Heart problems	self	family
Retinopathy	self	family	Thyroid	self	family
Eye injuries	self	family	Cancer	self	family
Eye surgery	self	family	General surgery	self	family
Allergies	self	family	Asthma	self	family
Migraine	self	family	Sleep Apnea	self	family

Please list **ALL** medications you are taking and for what reason: _____

Are you currently pregnant or breastfeeding? Yes No Have you ever had vision therapy/training? yes no

Have you ever worn (please circle) glasses contacts

How old are your present glasses? _____ When do you wear them? _____

Are you having any problems with your current contacts? _____

Have you noticed any changes in your vision? _____

What is your reason for examination today? _____

Date of last examination _____

Previous eye doctor (if not our office) _____

Primary health care provider _____

Please flip over & fill out both sides...