PATIENT INFORMATION

Name _____ ○ MR. ○ MRS. ○ MS. Soc. Sec. # _____
Last First Middle 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 ☐ Vision
Insurance Company _____ Group # _____ ID. # _____ ☐ Medical
Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Secondary ☐ Vision
Insurance Company _____ Group # _____ ID. # _____ ☐ 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 _____)
☐ Glaucoma Check
Last Visit Date _____ Service Date _____ ☐ Cataract Check
☐ Contact Lens Check
Last Exam Date _____ Date 1 (Date of First Visit) _____ ☐ Visual Field Test
☐ Other _____

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