Welcome to Our Office

Patient Name____
Last First Middle Initial

If Married, Name of Spouse________________If Child, Parent Name________________

Address____________________City________________State________ Zip__________

Phone (______) ________________________ Social Security #_______/_______/_______

Date of Birth _______-_______-_______ Age _________ Your Sex: ☐ Male ☐ Female

Place of Employment / School__________________ Business Phone (_____)______________

Occupation______________________________ E-Mail ______________________

Vision Care Plan ______________ VSP VCI Cigna Medicare # ____________________

Other Health Plan & Insurance # ____

List Activities / Hobbies you participate in that may require special vision care____________________

Date of Last Eye Exam:______________ Were your pupils dilated(drops) at last exam? ☐ Yes ☐ No

Are you wearing contact lenses? ☐Yes ☐ No Are you interested in wearing contact lenses? ☐ Yes ☐ No

If you currently wear contacts, do your backup eyeglasses have your correct prescription? ☐ Yes ☐ No

If you currently wear eyeglasses, does your spare pair have your correct prescription? ☐ Yes ☐ No

If you currently wear eyeglasses, does your prescription sunglasses have UV protection? ☐ Yes ☐ No

Have you had, or are you considering, laser vision correction? ☐ Yes ☐ No

Reason for Today's Visit: ____

Any Special Eye or Vision Problems ____

How were you referred to our office? _______________________________________

MEDICAL HISTORY

Medical Doctor ______________________________ Last Visit ______/_____/_____

Do you have any medical problems? Please check:

				Do You Use?		
Heart Disease	☐	Diabetes	☐	Cigarettes	☐ Y	☐ N
High Blood Pressure	☐	High Cholesterol	☐	Alcohol	☐ Y	☐ N
Thyroid Problems	☐	Cancer	☐	Other Substances	☐ Y	☐ N
Headaches	☐	Lung Disease	☐			
Sinus problems	☐	Allergies	☐			
Arthritis	☐	Asthma	☐			

Are you taking any Medications? ____

Are you allergic to any Medications?____

OCULAR HISTORY

Blurred Vision	☐	Cataracts	☐
Double Vision	☐	Glaucoma	☐
Tired when reading	☐	Tearing	☐
Spots / Floaters	☐	Dry Eyes	☐
Macular Degeneration	☐	Retinal Detachment	☐

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NEEDED TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY VISION INSURANCE.

Signature: ________________________________ Date: ______________

(OVER)⇨