

PERSONAL INFORMATION

PATIENT NAME <input type="checkbox"/> MS. <input type="checkbox"/> MRS. <input type="checkbox"/> DR. <input type="checkbox"/> MISS <input type="checkbox"/> MR.			DATE OF BIRTH	SOCIAL SECURITY#
ADDRESS		CITY	STATE	ZIP
HOME PHONE	DAYTIME PHONE	CELL PHONE	OCCUPATION	EMPLOYER
GRADE & SCHOOL	COMPUTER USE <input type="checkbox"/> YES <input type="checkbox"/> NO HOURS: DO YOU WEAR COMPUTER GLASSES <input type="checkbox"/> YES <input type="checkbox"/> NO	HOBBIES		NAME of PARENTS/SPOUSE
LIST ANY FAMILY MEMBERS WE HAVE SEEN:			E-MAIL ADDRESS	

GUARANTOR INFORMATION (if different from above)

NAME & ADDRESS		BIRTHDATE	SOCIAL SECURITY #
HOME PHONE	BUSINESS PHONE	OCCUPATION	EMPLOYER

MEDICAL HISTORY

NAME OF FAMILY PHYSICIAN & PHONE #	NAME OF LAST EYE DOCTOR PHONE # & DATE
WHAT IS THE MAIN REASON FOR YOUR FOR YOUR VISIT TODAY?	
ARE YOU INTERESTED IN LASER VISION CORRECTION? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU INTERESTED IN VITAMIN SUPPLEMENTS TO SLOW AGING OF EYES? <input type="checkbox"/> YES <input type="checkbox"/> NO
CIRCLE ANY THAT APPLY TO YOU: ALCOHOL ABUSE ALLERGIES ARTHRITIS ASTHMA CANCER DIABETES DRY EYES HEADACHES HEAD TRAUMA HEART DISEASE ILLEGAL DRUG USE ITCHY EYES HIGH BLOOD PRESSURE LUNG DISEASE RED EYES SEIZURES SINUSITIS SMOKER SUNGLASS WEARER VASCULAR DISEASE	
OTHER(S) LIST _____	
LIST ANY MEDICATIONS INCLUDING OTC & EYE DROPS AND WHY YOU TAKE THEM _____	
LIST ANY ALLERGIES TO MEDICATIONS _____	
CIRCLE ANY EYE CONDITIONS THAT APPLY TO YOU CONTACTS DRY EYES EYEGLASSES EYE INJURY GLAUCOMA LAZY EYE MACULAR DEGENERATION REFRACTIVE SURGERY TURNED EYE VISION THERAPY	
OTHER EYE DISEASES or SURGERIES (LIST) _____	
CIRCLE ANY CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS CATARACTS DIABETES GLAUCOMA HEART DISEASE HIGH BLOOD PRESSURE MACULAR DEGENERATION	
OTHER EYE DISEASES _____ OTHER INHERITED CONDITIONS _____	
LIST CHILDREN LIVING AT HOME & AGES _____	

CONTACT LENS HISTORY

<input type="checkbox"/> NEVER WORN CONTACTS <input type="checkbox"/> NOT INTERESTED IN CONTACTS <input type="checkbox"/> WOULD LIKE TO KNOW MY OPTIONS WHAT SOLUTIONS DO YOU USE? _____ _____ HOW OFTEN DO YOU CLEAN YOUR LENSES? _____	TYPE OF CONTACT LENSES _____ AGE OF CURRENT PAIR _____ LIST ALL TYPES OF CONTACTS YOU HAVE TRIED _____ _____ LIST ANY PROBLEMS WITH CONTACT LENSES _____
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HOW DID YOU FIND OUT ABOUT OUR OFFICE?

MAILOUTS PHONE BOOK NEWSPAPER TELEVISION LOCATION INS. CO. LIST DIRECT REFERRAL _____

PLEASE PROVIDE VISION AND HEALTH INSURANCE INFORMATION

PRIMARY'S NAME _____	PRIMARY'S BIRTHDAY _____	PRIMARY'S SS# _____
RELATIONSHIP TO PATIENT _____		
VISION INSURANCE COMPANY _____	POLICY# _____	
HEALTH INSURANCE COMPANY _____	POLICY# _____	GROUP# _____
MEDICARE _____		