

WELCOME BACK TO OUR OFFICE!

PERSONAL INFORMATION

DR. MS.
 MR. MRS.
 MISS

PATIENT NAME _____ DATE OF BIRTH _____
SS# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

OCCUPATION OR GRADE _____ EMPLOYER OR SCHOOL _____

E-MAIL ADDRESS _____

NAME OF PARENT OR SPOUSE _____

MEDICAL HISTORY

NAME, PHONE & ADDRESS OF PRIMARY CARE PROVIDER _____

PLEASE LIST ANY MEDICAL CONDITIONS _____

LIST MEDICATIONS INCLUDING OTC & EYE DROPS & WHY YOU TAKE THEM _____

LIST ANY ALLERGIES TO MEDICATIONS _____

HOBBIES / SPECIAL INTERESTS _____

ARE YOU EXPERIENCING DRYNESS, ITCHINESS, REDNESS OR DISCOMFORT OF YOUR EYES? YES NO

COMPUTER USE? YES NO IF YES - HOW MANY HOURS PER WEEK? _____ DO YOU WEAR COMPUTER GLASSES? YES NO

INTEREST IN LASER VISION CORRECTION? YES NO

ARE YOU INTERESTED IN VITAMIN SUPPLEMENTS TO SLOW AGING OF THE EYE? YES NO

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 _____