



# WELCOME TO OUR OFFICE!

Date \_\_\_\_\_

Dr.  Mr.  Mrs.  Miss  Ms.

(First) \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer/ School \_\_\_\_\_ Occupation/ Grade \_\_\_\_\_

Parent/ Guardian (if Minor) \_\_\_\_\_ Spouse (if married) \_\_\_\_\_

Number of Children \_\_\_\_\_ List names(s) & age(s) of children \_\_\_\_\_

What is the purpose of today's visit? \_\_\_\_\_

## EYE HISTORY

Do you currently wear glasses? YES NO Would you like to "test drive" the latest contact lens designs? YES NO

Are you considering getting new glasses today? YES NO Do you work on a computer? YES NO

Do you currently wear contacts? YES NO Do you have prescription sunwear? YES NO

Please tell us if you are currently being treated for any of the following:

Lazy Eye  Glaucoma  Diabetic Eye Problems  Macular Degeneration  Retinal Detachment  Cataracts  Dry Eyes

Other \_\_\_\_\_ Do any of your immediate family members have one of the above conditions? YES NO

If Yes, Specify who \_\_\_\_\_

## MEDICAL HISTORY

Name of Medical Doctor \_\_\_\_\_ Last Medical Exam \_\_\_\_\_

Please tell us if you are currently being treated or have been treated for any of the following:

Diabetes  High Blood Pressure  High Cholesterol  Heart Disease  Eye Surgery  Cancer  Other \_\_\_\_\_

List any medications you are taking: \_\_\_\_\_

\_\_\_\_\_ (Use reverse side if more space is needed)

List any allergies to medications: \_\_\_\_\_

## INSURANCE INFORMATION

Do you have Vision Insurance? YES NO Name of Insurance \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relation to patient \_\_\_\_\_

Do you have Medical Insurance? YES NO Name of Insurance \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relation to patient \_\_\_\_\_

If this is your first visit with us, who may we thank for referring you?

Dr. Referral  Phone Directory  Employee  Advertisement  Insurance Provider  Family/ Friend

Other (please specify so we can express our gratitude): \_\_\_\_\_