Our objective is to provide you the best of vision care. To do this it is necessary that we know everything we can about your eyes. This includes your seeing needs and present health condition. Please answer all questions about your vision. What may seem a silly answer to you might be the very thing that will make your problem clearer to us so we can help you to attain eye comfort and visual efficiency.

Name: _____ DOB: _____

Address: _____ Zip: _____

City, State: _____ Occupation: _____

Primary Phone: _____ Secondary Phone: _____

Spouse's Name: _____ Phone: _____

Spouse/Parents Employer: _____ Phone: _____

Parent's Name (if a minor): _____ Phone: _____

If in school, what grade/level? _____

How did you hear about us?:

Website ☐ Insurance ☐ Yellow/ GTE Superpages ☐ Other ☐

If referred by a person (or other source), whom may we thank?

_____

Insurance Information (please fill out completely)

We provide the service of billing your insurance company for you. Your co-payment (the portion of your bill that is not covered by insurance) is expected to be paid in full on the date of service.

Name of Primary Insured: _____

Primary's Date of Birth: _____ Primary's Last 4 Digits of SSN: _____

Insurance Company: _____ Phone: _____

Address: _____

City, State, Zip: _____

ID #: _____ Group #: _____

I authorize payment of benefits to my physician. I agree to be personally responsible for payment of all services rendered not covered by my insurance company. Also, by signing below, you acknowledge receiving our Notice of Privacy Practices.

Signature: _____ Date: _____

Most Recent Eye Exam:

Date: _____

Doctor: _____

Optometrist ☐

Eye Surgeon (Ophthalmologist) ☐

Do your parents/grandparents have any of the following:

Yes	No	
		Macular Degeneration?
		Glaucoma?
		Diabetes?

Do you have, or have you ever had, any of the following:

Yes	No	
		Heart Problems?
		High Blood Pressure?
		Diabetes?
		Thyroid Problems?
		Head or Eye Trauma?
		Glaucoma?
		Double Vision?
		Cataracts?
		Retinal Detachments?
		School Achievement Problems?

For What Purpose is Today's Visit:

Yes	No	
		Is this a periodic checkup?
		A medical issue?
Are you interested in:		
		Contact Lenses?
		Glasses or Sunglasses?
		Vision Therapy?
Other Information—Have you ever had:		
		Your eyes dilated?
		Any type of refractive surgery?

Are you taking any medications? If yes, please list: _____

_____

Please list any medications to which you are allergic: _____

What type of sports/activities do you do? _____

Are you satisfied with your current pair of glasses? (circle) Y / N

If not, what would you change about them? _____

How many hours are you on the computer each day? _____

Do you wear contacts (circle)? Yes / No Soft / Hard

How often do you change out your disposable lenses? _____

Do you sleep in your contacts? Y / N

What lens cleaning solution do you use? _____

How may we contact you?

Email_____

Text message/ cell number:_____