WELCOME TO OUR PRACTICE

At today's visit, I would like:

_____ Eye health exam
_____ Glasses exam
_____ Contact lens exam
_____ Consultation about computer-related eyestrain
_____ Consultation about refractive surgery or non-surgical vision correction

PATIENT INFORMATION

Date_____ Soc Sec # _____Birth Date _____

Name_____
First Name M.I. Last Name

Sex ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address _____ Home Phone _____

City _____State_____ Zip Code_____ Email _____

Employer_____ Business Phone _____

Occupation _____

School _____ Grade _____

PRIMARY INSURANCE

Person responsible for account_____
First Name M.I. Last Name

Sex ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Birth Date _____Soc Sec # _____ Relationship to patient_____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Responsible party employed by _____Business Phone _____

Vision insurance company_____Address _____

If medical insurance is different from vision insurance, please list medical insurance carrier:

_____

Do you have secondary insurance? If yes, list carrier:_____

Patient ID #_____ Group # _____

Please complete reverse side.

Please give the front office all glasses and/or contact lens boxes/ packets that you brought with you today.

EYE GLASSES/CONTACTS

Have you ever worn glasses? ___Yes ___No Have you ever worn contact lenses?___Yes ___No

Do you presently wear glasses? ___Yes ___No
Type of glasses: ___Distance ___Reading ___Bifocals

Do you presently wear contact lenses?___Yes ___No
Type of contact lenses: ___Disposable ___Soft ___Gas Perm

My contact lenses become less comfortable as the day progresses.___Yes ___No

I am interested in learning about new contact lens technologies.___Yes ___No

Have you ever had any type of eye surgery, disease, or injury?___Yes ___No

If yes, please provide a brief description and approximate date:

_____

_____

Is there a family history of any eye disease, such as cataracts, glaucoma, or retina problems? ___Yes ___No
If yes, please provide details of which family member(s) had which condition(s):

_____

MEDICAL HISTORY

Are you under a physician's care or taking prescription medication for any reason?___Yes ___No
If yes, please list conditions and any medications _____

Do you have any environmental allergies or hay fever?___Yes ___No
List medications to which you are allergic _____

Name of family doctor_____ Approx. date of last visit _____

PAYMENT POLICY

Payment for professional services is required on the day services are provided. If glasses or contact lenses are prescribed, these are also to be paid in full at the time of ordering. Glasses are ordered specifically to match your requirements. **No refunds or exchanges will be made**. If your insurance company contracts to pay the doctor directly, applicable co-payments or deductibles are required the day services are provided. I agree that I am personally responsible for payments as per the policy above.

_____ _____
Signature Date

Method of payment: _____Cash _____Check _____Visa _____MasterCard _____Discover

Has anyone in your household ever been a patient of ours?___Yes ___No Who?_____

Whom may we thank for referring you to us? _____