

PATIENT INFORMATION
COMPLETE INFORMATION HELPS US HELP YOU
PLEASE UPDATE OR COMPLETE FULLY

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ Zip _____

Telephone (H) _____ (W) _____ (C) _____

SSN _____ - _____ - _____ Date of Birth ____/____/____

Occupation: _____ Employer: _____

Emergency Contact/ Relationship/ Phone Number _____

Family Physician _____ Last Eye Doctor _____

Date of Last Eye Exam ____/____/____ Dilated? Y/N

Please fill out in entirety:

Reason for Today's Eye Exam: _____

Special visual needs? _____ Computer Use? Y/N How Much? _____

Do your eyes Burn? Y/N Ache? Y/N Tire? Y/N Water? Y/N

Itch? Y/N Feel Dry? Y/N Look Red? Y/N

Do you wear contacts now? Y/N If yes, what type? _____

If not, Why? _____ Are you interested in wearing contact lenses? Y/N

Health Insurance _____ Vision Insurance _____

Primary Insured Name _____

SSN _____ - _____ - _____ Birthdate ____/____/____

A THOROUGH EYE EXAMINATION REQUIRES THAT WE PUT DROPS IN YOUR EYES. YOUR VISION WILL BE BLURRY (ESPECIALLY NEAR) FOR 4 TO 6 HOURS. YOU WILL ALSO BE MORE SENSITIVE TO LIGHT. WE WILL PROVIDE YOU WITH DARK GLASSES.

Payment for Services is due when Services are Rendered.
Visa, Mastercard, American Express and Discover Card are accepted.

Signature _____ Date _____

Patient or Parent if Patient is under 18

Who May We Thank for Referring You? _____