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? _____