

Welcome to Our Office

In order to serve you better, please fill out these information sheets. Please print and complete all entries.

Patient (Last-First-Middle) _____ Home Phone _____
 Address _____ Cell Phone _____
 City/St _____ Zip _____ Drivers License No. _____
 Date of Birth _____ Age _____ Social Security No. _____
 Email Address _____ Marital Status _____
 Occupation _____ Employer _____ Work Phone _____

How Did You Choose Our Office? Referred by (name _____)
 Insurance Plan Office Location Yellow Pages Other _____

Legally Responsible Person (if patient a minor) _____ Home phone _____
 Relationship to patient _____ Drivers License No. _____ Social Security No. _____
 Address _____ City/St _____ Zip _____
 Employer _____ Phone _____ Marital Status _____

METHOD OF PAYMENT TODAY WILL BE: Cash Check VISA / MasterCard / Discover / American Express

Vision Insurance _____ Group No. and Member No. _____ Name of Insured _____
 Major Medical Insurance Co. _____ Group No./Membership No. _____

When was your last eye examination? _____

Please check all that apply:

<input type="checkbox"/> Blurred distance vision	<input type="checkbox"/> Tired eyes	<input type="checkbox"/> Redness	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blurred near vision	<input type="checkbox"/> Eyestrain	<input type="checkbox"/> Sandy/gritty feeling	_____
<input type="checkbox"/> Poor night vision	<input type="checkbox"/> Glare or light sensitivity	<input type="checkbox"/> Eyes burn, itch or water	_____
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Eye pain or soreness	<input type="checkbox"/> Double vision	_____

If you use glasses, when do you wear them?

All the time Reading/near work When using computer Distance tasks only Work safety

Have you ever worn contact lenses? Yes No

Are you considering contact lenses? For daytime wear For occasional wear
 For wear continuously up to one month Haven't considered
 I already wear Not interested

Do you use a computer? Yes No If so, estimate how many hours per day or per week: _____ hours per _____
 What hobbies or sports do you participate in? _____

Would you like to discuss the latest LASER surgery that reduces the need for glasses or contacts? Yes No

Authorization

I certify that the above information is true and correct to the best of my knowledge. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers. Because there is no guarantee that my insurance will pay for services rendered, I also understand and agree that I am ultimately responsible for payment.

Print Name of Legally Responsible Person _____

Signature of Legally Responsible Person _____ Today's Date _____

If not patient's signature, what is your relationship to patient? _____