



WELCOME!

PERSONAL INFORMATION

Name: (LAST) (FIRST) Sex: M F Date of Birth: / / Age:

Address: Street City State Zip

1st Main Phone: () 2nd Phone: () Social Security #: - -

Employer: Occupation: E-Mail:

INSURANCES

VISION INSURANCE:

Circle all that apply: VSP, MES, EyeMed, Spectera, Delta, Safeguard, Superior, Tricare, Others:

Member Name: DOB: / / SS#: Relationship to Pt:

MEDICAL INSURANCE: (All medically related eye visits are billed to your Medical Insurance)

Circle all that apply: Blue Cross/Shields, Medi-Care, Kaiser, Pacific Care, Cigna, Aetna, United Health, Others:

Member Name: DOB: / / SS#: Relationship to Pt:

WHAT IS THE REASON FOR TODAY'S VISIT? (Check all that apply)

- I have an Eye Disease or Eye Problem requiring examination:
I want Glasses: Age of present glasses:
Is there a time when your glasses get in the way of your activities?
Would you like to try (for free) a pair of contact lenses today?
I want Contact Lenses: Clear Colored Brand? Solution?
First time trying contact lenses?
I am interested in Lasik Refractive Surgery or Corneal Refractive Therapy
How soon? (Circle One) 1mo. 3mo. 6mo. 1yr. Undecided

DO YOU EXPERIENCE ANY OF THE FOLLOWING? (Check all that apply)

Table with 3 columns and 4 rows of symptoms: Distance vision blurred w/ glasses, Dry/ Burning eyes, See flashing lights, Near vision blurred w/ glasses, Watery eyes, See floaters or spots, Headaches related to eyes, Itchy eyes, Double Vision, Eye strain, Red eyes, Sensitivity to lights

MEDICAL AND EYE HISTORY (Check all that apply to you or your immediate family)

Table with 2 main sections: Last Eye Exam and Last Physical Exam, each with columns for Self and Family, and rows for Diabetes, High Blood Pressure, Heart Condition, Cholesterol Problems, Asthma, Thyroid Problems, Sinus Problems, Cancer, Glaucoma, Cataracts, Lazy/Cross Eye, Retinal Disease

- Are you pregnant? (if applicable)
Are you currently taking any medication?
Are you allergic to any medication?
Have you had any eye surgery or injury?

Who may we thank for kindly referring you to our office?

PATIENT SIGNATURE (If under 18, parent signature required)

DATE

THANK YOU!