



office use only

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WELCOME TO OUR OFFICE

In order that we may serve you better, please complete the following information sheet for our records. This information will become part of your office records, and will be held in strict confidence.

NAME: MR. MRS. MS. MISS (CIRCLE ONE) FIRST MIDDLE INITIAL LAST

ADDRESS: ZIP:

DATE OF BIRTH: SEX: HOME PHONE

SOCIAL SECURITY NUMBER: CELL PHONE

EMPLOYER: WORK PHONE EXT.

OCCUPATION:

Person responsible for your account (if other than yourself) Please list any insurance coverage which may apply to your visit.

NAME:

ADDRESS:

Is this your first visit to this office? Y N

If so, whom may we thank for referring you?

Professional fees for all services are payable at the time services are rendered. 50% of fees for contact lenses and eyeglasses are payable at the time they are ordered and the balance at the time they are dispensed.

Signature

Date

PLEASE CONTINUE ON OTHER SIDE

HEALTH SUMMARY

EYE HEALTH

When was your last eye examination? _____

Who was your previous eye doctor? _____

Please circle any of the following disorders that you currently have or have had in the past.

Glaucoma	Crossed Eyes
Double Vision	Itchy Eyes
Eye Surgery	Eye Injuries
Light Flashes	Halos Around Lights
Tunnel Vision	Cataracts
“Floaters” - recent onset	Cataract Surgery
Amblyopia (lazy eye)	

Please circle any of the following disorders that a member of your immediate family currently has or has had in the past.

Diabetes	High Blood Pressure
Blindness	Glaucoma
Eye Disease	

Have you ever had problems adjusting to a pair of eyeglasses?	Yes	No
Have you ever worn contact lenses?	Yes	No
If not, have you ever considered contact lenses?	Yes	No
Do you work or participate in any sports where there is an eye hazard?	Yes	No

GENERAL HEALTH

Who is your primary (family) physician? _____

When was your last physical examination? _____

Please circle Yes or No

Do you have any allergies, including drug allergies?	Yes	No
If so, please list _____		
Do you have sinus trouble?	Yes	No
Do you have frequent headaches?	Yes	No
Are you currently under a physician's care?	Yes	No
If yes, for what reason? _____		
Are you presently taking any medications?	Yes	No
If so, please list (include birth control pills) _____		

Please circle any of the following disorders that you currently have or have had in the past.

Heart Trouble	High Blood Pressure
Blood Vessel Disease	Thyroid Problem
Asthma	Epilepsy
Diabetes	Anemia