WELCOME TO OUR OFFICE

NAME ______________________________________ _ TODAY'S DATE __________ LAST EXAM DATE ___________

NICKNAME ___________________________________ BIRTH DATE _____________ AGE _______ SEX M F

ADDRESS ____________________________________ SPOUSE (OR PARENT) NAME __________________________

CITY ______________________________________ _ YOUR E-MAIL ADDRESS _____________________________

STATE ___________ ZIP _______________________ HOBBIES ____

HOME PHONE ________________________________ HOW WERE YOU REFERRED TO OUR OFFICE _____________

EMPLOYER __________________________________ ____

OCCUPATION ________________________________ VISION INSURANCE COMPANY / ID # ____________________

WORK PHONE ________________________________ ____

SSN _______________________________________ DO YOU PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT Y N

HOW WILL YOU SETTLE YOUR ACCOUNT TODAY?

CASH CHECK CREDIT CARD

PERSONAL & FAMILY MEDICAL HISTORY

	SELF	FAMILY		SELF	FAMILY
ALLERGIES	___	___	GLAUCOMA	___	___
ASTHMA	___	___	EYE DISEASE	___	___
ARTHRITIS	___	___	HEART DISEASE	___	___
CANCER	___	___	EYE INJURY	___	___
DIABETES	___	___	EYE SURGERY	___	___
			HIGH BLOOD PRESSURE	___	___

CURRENT MEDICATIONS (RX AND OTC)

			DRUG NAME
ANTIHISTAMINES	Y	N	______________________
BLOOD PRESSURE	Y	N	______________________
ORAL CONRACEPTIVES	Y	N	______________________
EYE DROPS	Y	N	______________________

OTHER ____

MEDICATION ALLERGIES? Y N ______________________

ARE YOU CURRENTLY UNDER PHYSICIAN'S CARE Y N PHYSICIAN'S NAME _________________________________

DO YOU HAVE MORE THAN 1 PAIR OF CURRENT Rx GLASSES	Y	N
DO YOU WORK ON A COMPUTER FOR LONG PERIODS	Y	N
IF YOU WEAR GLASSES, WOULD YOU BENEFIT FROM THINNER LIGHTER LENSES	Y	N
DO YOU SPEND A LOT OF TIME OUTDOORS	Y	N
IF YOU WEAR BIFOCALS, ARE YOU BOTHERED BY LINES OR HEAD TILTING	Y	N
ARE THERE TIMES WHEN YOU WOULD RATHER NOT WEAR GLASSES	Y	N
DO YOU WEAR CONTACT LENSES AND IF SO WHAT TYPE ___________________	Y	N
ARE YOU INTERESTED IN A 'TEST DRIVE' OF THE LATEST IN CONTACT LENS DESIGN	Y	N
ARE YOU INTERESTED IN LASER VISION CORRECTION	Y	N

DO YOU EXPERIENCE?

ANY DISCOMFORT WITH YOUR EYES	Y	N
PROBLEMS WITH GLARE OR REFLECTION	Y	N
SENSITIVITY TO LIGHT	Y	N
HEADACHES	Y	N
FLOATERS OR FLASHES OF LIGHT	Y	N

I UNDERSTAND THAT ALL CHARGES ARE MY RESPONSIBILITY TO PAY. IF I CARRY INSURANCE, I REALIZE THAT INSURANCE PAYMENTS DO NOT ALWAYS COMPLETELY COVER ALL FEES AND THAT I AM RESPONSIBLE FOR THE AMOUNT NOT COVERED.

SIGNATURE ____ DATE ___________________