Welcome to our office. The following information will help our Doctors and Staff to more efficiently serve your needs. We appreciate a moment of your time to help us.

Patient's Name:_____ Birth Date: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Social Security Number:_____

Parent Name (must be filled out for minor children)_____
Address if different from above _____

Patient's Employer _____ Business Phone _____

Do you have vision insurance? _____ If yes, please fill out insurance information form.

If anyone, who might we thank for referring you?_____

When was your last eye examination? _____ By whom? _____

Are you currently under the care of a physician? Y N
Physician's Name? _____ Treated For?_____
Medications: _____

Do you have any allergies to any medications? Y N
Please list: _____
Any ocular medications? _____

Have you ever had a severe head trauma? Y N

Do you suffer from headaches? Y N
Do you believe them to be due to vision Y N

Are you in need of or undergoing dental care? Y N

Is there a family history of:

High/Low Blood Pressure?	Y N
Thyroid Disease?	Y N
Heart Disease?	Y N
Diabetes (Sugar)?	Y N
Glaucoma?	Y N
Macular Degeneration?	Y N
Crossed/Lazy eye?	Y N

Have you ever had surgery on your eyes? Y N

Have you ever injured your eyes? Y N

Have you ever had a dilated eye exam? Y N

Have you ever worn contact lenses? Y N Brand? _____ Solution?_____

Please continue to the back side. Thank you.