Welcome to our office! It is our desire to provide you with the very best in vision care. We realize your time is valuable and our staff will try to attend to you as quickly as possible. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records. (PLEASE PRINT).

Date ____________________________

PATIENT INFORMATION

Patient ____
Last name First name Initial Prefer to be called

Address ____

City ____________________________________ State ______________ Zip ________________

Gender □ M □ F □ Prefer not to answer Marital Status: Married Single Other

Race □ American Indian or Alaska Native □ Asian □ Black or African American □ Declined to Specify □ European □ Hispanic □ Native Hawaiian or Other Pacific Islander □ Other □ White

Date of Birth ________________ Last 4 of SSN ________________ Email Address ____________________

Home Phone ____________________ Work Phone ____________________ Cell Phone ______________

Employer (or school) ______________________________ Occupation (or grade) ____________________

Emergency Contact/Relationship ______________________________ Phone ______________________

Family members who are patients ____

Whom may we thank for referring you to our office? ______________________________________

MEDICAL INSURANCE

Plan Name ______________________________ Member ID ________________ Group # ____________

Primary Insurance Holder Name ______________________________ Primary DOB ______________________

Primary's Address ______________________________ City ________________ State_______ Zip___________

VISION INSURANCE

Plan Name ______________________________ Member ID ________________ Group # ____________

Primary Insurance Holder Name ________________________ Primary DOB __________ Primary Last 4 of SSN ______

Primary's Address ______________________________ City ________________ State_______ Zip___________

Employer ______________________________ Work # ________________________________

EYE HISTORY/ MEDICAL HISTORY: * Additional medical data / medication information will be gathered in office

Do you have dry eyes? ☐ Yes ☐ No

How many hours per day do you work on a computer? ______ Do you have any other specific visual demands? ____________

Have you ever worn contact lens? ☐ Yes ☐ No Are you interested in wearing contact lenses? ☐ Yes ☐ No

Do you have prescription sunglasses? ☐ Yes ☐ No Are you interested in refractive surgery (Lasik)? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

SOCIAL HISTORY

Do you drive? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long? ______________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long? ______________________________

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long? ______________________________

Have you been exposed to or infected with: ☐ HIV ☐ Hepatitis