WELCOME TO OUR OFFICE

Name_____ Date_____

If minor, Parents or Legal Guardian_____

Mailing Address_____ City_____
Zip_____

Home phone_____ Cell/Work Phone_____
Texting _yes __no

Employer_____Occupation_____

Date of Birth___/___/___ Email_____

Whom may we thank for referring you? __Family __Yellow Pages
__ Friend

GENERAL HEALTH HISTORY (please check if YES)

__Headache __Dry eyes __Heart Condition __Arthritis
__ High Blood Pressure __Pregnancy __Eye Surgery __ Other
__Diabetes __Allergies __Eye Disease
__Thyroid Condition __Asthma __Drug Allergies

Please List Present Medication (including birth control pills)

FAMILY HISTORY (please check if YES)

__Glaucoma __ Lazy Eye __ Cataracts __Keratoconnus __Macular Degeneration
__ Retinal Detachment

Primary reason for today's visit?

_____

Date of last exam_____ Date of last physical exam _____

Do you presently wear glasses? __yes __no
Do you presently wear contact lenses? __yes __no
Are you interested in contact lenses? __yes __no
Are you interested in LASIK (laser vision correction)? __yes __no

Fees for professional services are due on day of service. Fees not covered by insurances are the responsibility of the patient.

I have read and understood the above policy **X**_____