We are now computerized in order to better serve you, please fill out this form completely
If you have filled one out before on a previous visit, just let us know of any changes since then.

PLEASE PRINT

PATIENT INFORMATION:

Patient's Name _____ DOB_____ /_____/_____ Age _____

Title: ☐ Miss ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Other _____ ☐ Guarantor _____

Address _____ City _____ State_____ Zip_____

Phone: Home_____Work _____ Cell _____ ☐ Male ☐ Female

Social Security # _____Favorite Hobby _____

Employer _____Occupation _____ Vision Ins._____

Medical Ins. _____Member Name/Mem.#_____

I was referred by: ☐ TV ☐ Internet ☐ Facebook ☐ Website ☐ Coupon ☐ Insurance Company

☐ Friend / family (Name) _____☐ Other_____

HEALTH INFORMATION:

Have you ever worn glasses? Yes_____ No_____ Bifocals, Trifocals, or Progressives?

Have you ever worn contact lenses? Yes_____ No_____ rigid (hard) or soft? _____

If so, what brand? _____ What solutions? _____

Is this an exam for new contact lenses? Yes____No____ Possibly:_____

Are you interested in laser vision correction? Yes_____ No_____

Are you interested in a non-surgical form of correcting your vision? Yes_____ No_____

Dear Patient:

An eye examination includes evaluation of your eyes to be sure there are no diseases affecting your eyes and vision, as well as determination of your prescription for distance and near vision.

To determine the health of your retina (the back of your eyes), I suggest dilating your eyes. It is uncomfortable for a few hours, but allows for a more thorough examination.

Glaucoma and Cataracts will be checked regardless of dilation.

Your vision may remain slightly blurry for 3 - 5 hours.

I DO_____ DO NOT_____ WANT MY EYES DILATED AT THIS TIME.
I understand that I may need to see a Medical Doctor if any disease is found.

Signature_____ **Date** _____ / _____ /_____