DATE_____

Patient's Name (Mr., Mrs., Miss, Dr. )_____

Age_____ DOB_____ If student, grade_____

Address_____ City_____ Zip_____

Home Phone_____ Business Phone_____ cell_____

Employer _____ Occupation_____

HOW DID YOU FIND US? Phonebook_____ Internet_____ Newspaper____ Insurance____ Walked By__
Former patient_____ Referred by a patient _____ Name of referring patient _____

Medical Information: Check if you have or have had:
Allergies___ High Blood pressure_____ Epilepsy_____
Sinusitis____ Arthritis_____ Drug Sensitivity_____ Eye injury_____
Migraines___ Hypoglycemia_____ Eye disease_____ Glaucoma_____
Diabetes____ Blood disease_____ Eye surgery_____ Currently pregnant_____
HIV/AIDS___ Other_____

Name of medications used:_____
Check if your eyes are bothering you in the following ways:

Blur____ Water_____ Tire_____ Floaters_____
Headaches_____ Burn_____ Ache____ Redness_____
Double Vision____ Itch_____ Dry_____ Glare_____
Night Blindness____ Other_____

Do you wear glasses now? _____ Contact lenses?_____ Last eye exam date_____
Are you interested in contact lenses?_____

It is customary to pay for professional services at the time they are rendered. Fees are payable by Cash, Check, Visa, Mastercard, Discover

Signature_____