PLEASE FILL OUT AS COMPLETE AS POSSIBLE. THANK YOU!!

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.** **PERSONAL INFORMATION** ☐ **MALE** ☐ **FEMALE**

Patient's last name:	Patient's first name:	Middle Initial:	Birthdate:	Age:

Address:	City	State	Zip

Home Phone (evening)	Business Phone (Daytime)	Employer/Name of School	Occupation/Student's Grade Level

Name of Parent or Spouse	e-mail address	Driver's License #	State

Name of Vision Insurance Company	S.S.# (required if using Insurance)	Have we seen other members of your family? ☐ NO ☐ YES WHO?

MEDICAL & VISUAL HISTORY

Reason for Today's Visit:

☐ Poor Distance Vision
☐ Poor Near Vision

List Any medical conditions you are being treated for and for how long: (Including Pregnancy)

List any and all medications you are currently taking (include hormones/birth control/non-prescription/herbal remedies)

Are you allergic to any medications? ☐ No. No Known Drug Allergies ☐Yes: If so please list.

Check all medical conditions that apply to **you**:

☐ Stroke/ TIA's ☐ Kidney Disease ☐ Asthma ☐ Cancer Type:_____
☐ Vascular Disease ☐ Lung Disease ☐ Arthritis ☐ Headaches ☐ Mental Disabilities
☐ High Blood Pressure ☐ Thyroid Disease ☐ Diabetes ☐ High Cholesterol ☐ Seasonal Allergies
☐ Head Trauma ☐ Heart Disease ☐ Seizures ☐ Gastro/Intestinal ☐ Pregnancy ___Weeks
☐ Past Trauma_____ ☐ Other: (Please List) _____

Check all eye conditions that apply to **you**:

☐ Eye Surgery type_____ ☐ Cataracts ☐ Glaucoma Treated by:_____
☐ Lazy Eye ☐ Strabismus (eye turn) ☐ Keratoconus ☐ Retinitis Pigmentosa ☐ Prosthesis
☐ Light Flashes ☐ Dry Eyes ☐ Corneal Transplant ☐ Macular Degeneration ☐ Vision Therapy
☐ Past Eye Injuries: _____ ☐ Other: (Please List) _____

Check conditions that are present in **other** family members:

☐ Cataracts before age 60 ☐ Glaucoma ☐ Diabetes ☐ Cancer Type:_____
☐ Macular Degeneration ☐ High Cholesterol ☐ Stroke/TIA's ☐ High Blood Pressure ☐ Heart Disease
☐ Other **EYE** Diseases (please list) _____
☐ Other Inherited Conditions (please list) _____

CONTACT LENS HISTORY

☐ Have you ever worn contacts? _____ ☐ Are you here for a contact lens prescription today? _____
☐ When was the last time you wore contacts?_____ ☐ How many days a month do you sleep in your contacts? _____

Please check which kind of contacts you currently wear, or are interested in:

☐ Daily Wear (1 pair for the year) ☐ Extended Wear (can sleep in) ☐ Disposables: How often do you throw each pair away?_____
☐ Rigid Gas Permeable ☐ Bifocal ☐ Toric/Astigmatism ☐ Colors
☐Problems with contacts: ☐Dry ☐Uncomfortable ☐ Blurry ☐ Other _____
Brand of Current Contacts:_____ Solution you currently use:_____

WORK ACTIVITIES, HOBBIES, & INTERESTS

☐ Football/ Basketball ☐ Baseball/Softball ☐ Gymnastics ☐ Soccer ☐ Martial Arts ☐ Computers _____ hrs/day
☐ Swim/ Water Sports ☐ Scuba Diving ☐ Cheerleading ☐ Dusty work environment ☐ Other:

Please read and sign the following

Failure to pay your bill in a timely manner may result in additional charges for interest, documentation fees, bank fees, billing fees, collection agency fees, or any other applicable fees.

Insurance is accepted on good faith is not a guarantee of benefits. In the event your vision insurance provider determines that you are not eligible for vision insurance coverge at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by your insurance provider.

Patient's/Guardian's Signature:_____ Date: _____