Welcome To Our Office

Patient Name____

Parent/Spouse____

Social Security Number OR Unique Member Number______________________________

Insurance ____________________Policy Number__________________Insured Name____________

Home Address_______________________________City_______________________Zip_________

Home Phone______________________Cell______________________Work_________________

Date of Birth____Age_______________

Occupation________________________________How did you hear about us?________________

General Medical History:

Do you have any health problems?____

Are you taking any medications? Yes_____No_____

If yes, please list:____

Do you have: High Blood Pressure__________ Diabetes________________ Cancer________________

Headaches________________ Heart Problems __________ Migraines______________

Do you or any family member have or have had the Covid 19 Virus?_____________

Eye Health History:

Do you wear glasses or contact lenses?__________ If yes, for what reason?______________________

When was your last eye exam?_________Where?______________________________________

Do you or any blood relative have the following:

Glaucoma______ Eye Pain______Light Sensitive_____Flashes of Light_______Stye_____Itchy_____

Cataracts_______Tearing________Floaters_______Spots______Double Vision_____Red Eyes_____

Lazy eye, eye turn_____________________________

Patient Signature:____

A 50% deposit is required on all orders. Thank you