

"Vision Care From Our Family To Yours"



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## WELCOME TO OUR OFFICE

|                                  |   |
|----------------------------------|---|
| Name _____                       | Date of Last Exam _____                 |
| Street _____                     | Date of birth _____ Age _____ Sex _____ |
| City _____ State _____ Zip _____ | Vision insurance _____                  |
| Home phone _____                 | Spouse's name _____                     |
| Work phone _____                 | Spouse's work phone _____               |
| Occupation _____                 | Your Employer _____                     |
| Social Security No. _____        | Driver's License No. _____              |

What is the purpose of your visit today? \_\_\_\_\_

Free-time activities \_\_\_\_\_

How will you settle your account today?  Check  Cash  Credit card

Do you participate in a flexible spending account? \_\_\_\_\_

|   |  |
|---|--|
| <b>How did you hear about our office?</b>                         | <b>Have you ever had any:</b>          |
| <input type="checkbox"/> Friend or relative. Who? _____           | Eye injuries _____                     |
| <input type="checkbox"/> Another doctor. Who? _____               | Eye infections _____                   |
| <input type="checkbox"/> Yellow pages. Which one? _____           | Eye surgery _____                      |
| <input type="checkbox"/> Radio announcement. Which station? _____ | <b>Your Current Medications (List)</b> |
| <input type="checkbox"/> Vision care plan                         | _____                                  |
| <input type="checkbox"/> Other _____                              | _____                                  |

### Diagnostic Issues

Please list any problems with your vision, or problems with wearing glasses or contact lenses. \_\_\_\_\_

Y N Do you have more than 1 pair of current glasses?

Y N Do you work on a computer for long periods?

Y N If you wear glasses, would you benefit from thinner, lighter lenses?

Y N Do you spend a lot of time outdoors?

Y N Are there times when you would rather not wear glasses?

Y N Are you interested in a "test drive" of the latest in contact lens designs?

Y N Would you like information regarding laser vision correction or a free evaluation of your suitability?

Y N Is there anyone in your family that has not had their eyes checked in the last three years?