

WELCOME TO OUR OFFICE!!

If you will be kind enough to give us some basic information for our files, it would be much appreciated. Our office is open everyday except Tuesday. We have evening hours on Monday and Wednesday along with Saturday morning.

Patient Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone # _____ Business # _____

Patient SS# _____ Employer _____

Occupation _____

If Student, Grade & School _____

Referred By _____

Just some basic information here. The Doctor will ask you more questions & you can further explain, directly to him.

Last eye exam _____ Today's Date _____

If not presently a contact lens wearer, would you be interested in wearing contacts? _____

Have you ever had any eye injury, surgery or disease? _____

Are you experiencing any eye strain at distance or near? _____

Do you have trouble reading street signs or small print? _____

PLEASE CHECK ANY OF THE FOLLOWING, PAST OR PRESENT

- | | | | |
|---------------|-------------------------|---|---------------|
| ___ Allergies | ___ High Blood Pressure | ___ Heart Disease | ___ Cataracts |
| ___ Asthma | ___ Dry Eye Syndrome | ___ Glaucoma | ___ Emphysema |
| ___ Fainting | ___ High Cholesterol | ___ Head Injury | ___ Hay Fever |
| ___ Diabetes | ___ Skin Condition | ___ Cysts, Sty or other eyelid conditions | |

Please list all medications (including birth control) _____

*Our office abides by all HIPPA standards. Please feel free to request a copy of our policy.