WELCOME TO OUR OFFICE

Today's Date_____

Patient Name _____Gender: Male☐ Female☐ Date of Birth_____

Address_____City_____ Zip_____

Home Phone_____ Cell Phone_____Social Security#_____

Email _____ Occupation_____

Employed By _____ Business Phone_____ Ext:_____

HEALTH INFORMATION:

Primary Doctor: First Name_____Last _____ Phone_____

Present Medications:_____

_____

INSURANCE INFORMATION:

Primary Medical Insurance_____ Do you need a referral from your PCP? Y / N

Policy Holder's Name_____ DOB ___/___/___ Id #_____

Group #_____ Secondary Insurance_____

Policy Holder's Name_____OB _____/_____/___Id #_____

Vision Insurance_____

Policy Holder's Name_____DOB ____/_____/_____ Social Security # _____

FAMILY INFORMATION:

Emergency Contact:_____Phone:_____

Family Members_____

If married, name of spouse_____

If child, name of parent_____

Child's School_____Child's Grade_____

Hobbies or sports played:_____

How old are your present glasses/contacts?_____

How much time do you spend outdoors? _____hours per week

Do you work at a computer more than two hours per day? Yes☐ No☐

Do you want or need to read faster? Yes☐ No☐

Are you interested in preventative health care? Yes☐ No☐

Whom may we thank for referring you to us?_____

(Over)