

**Welcome to our office!**

Please fill out this form as completely as possible and return it to the desk along with your **ID** and **Insurance Card**.

Name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Mailing address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Email address \_\_\_\_\_ DOB \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Primary Care Doctor \_\_\_\_\_ Referred by \_\_\_\_\_

**Insurance Information**

Medical Insurance \_\_\_\_\_ Vision Insurance \_\_\_\_\_

**Medical History**

Drug Allergies \_\_\_\_\_  
 Medications \_\_\_\_\_  
 Eye Injuries/Surgeries \_\_\_\_\_

\_\_\_ Dry Eye    \_\_\_ Iritis or Uveitis    \_\_\_ headaches    \_\_\_ poor night vision    \_\_\_ double vision  
 Are you diabetic? \_\_\_yes \_\_\_no. If yes, who is your physician? \_\_\_\_\_  
 Do you suffer from Hypertension? \_\_\_ yes \_\_\_no If yes, who is your physician? \_\_\_\_\_  
 Are you currently pregnant or nursing? \_\_\_yes \_\_\_no

**Family Medical History: Note relation to yourself in the box (ex: self, mother, father, sister, brother, etc)**

___ Blindness _____	___ Cancer _____
___ Cataracts _____	___ Diabetes _____
___ Macular Degeneration _____	___ Hypertension _____
___ Glaucoma _____	___ Lupus _____
___ Retinal Detachment _____	___ Thyroid Dysfunction _____
___ Crossed Eyes _____	

Other: \_\_\_\_\_

\_\_\_ I wear glasses    \_\_\_ I wear contacts    \_\_\_ I would like to try contacts  
 What brand of contacts do you currently wear? \_\_\_\_\_  
 Approximately how many hours do you spend on digital devices/computers per day? \_\_\_\_\_  
 What is your reason for this visit? \_\_\_\_\_

**\*\*No Checks Accepted\*\***

**\*Payment is expected when services are rendered.**