VISUALIZE OPTOMETRY

Welcome to Our Office

FOR OFFICE USE ONLY
Appt. Time _____
Walk-in _____

Personal Information:

Name: _____ ☐ Male ☐ Female Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (☐ Cell: Text OK ____ ☐ Home ☐ Work) Additional Phone: _____

Occupation: _____ Employer: _____

Email: _____ (OK to use ☐) Date of Birth: _____ Age: _____

Name of Spouse or Parent (if patient is a minor) _____

Minor _____ Single _____ Married _____ Other _____

Payment:

☐ Self ☐ Cash ☐ Electronic Check (DL# _____) ☐ Visa/MC/Amex/Disc ☐ Insurance (Fill out next section)

(NOTE: For all check and credit card purchases, account holder must be present)

Please fill out the following section if you are using Superior Vision, Davis Vision or Vision Service Plan (VSP) **out-of-network** insurance for your services.
Name of Vision Insurance Carrier: _____

Name of Insured: _____ D.O.B: _____ SS# _____

Employer: _____ ID# _____

How did you hear of our office? Newspaper _____ Internet _____ TV Ad _____ Walk-in _____ Eyemart Express _____

Yellow Pages _____ Family/Friend (whom may we thank for referring you?) _____

Ocular History:

When was your last eye exam? _____ Doctor/Clinic: _____

Do you currently wear glasses? ☐ Yes ☐ No What type: ☐ Single vision ☐ Bifocal

Do you wear contact lenses? ☐ Yes ☐ No Do you sleep in your lenses? ☐ Yes ☐ No

Type of lenses? ☐ Soft (brand?) _____ ☐ Rigid ☐ Other _____ How often do you replace them? _____

Have you previously worn contact lenses? ☐ Yes ☐ No

Are you interested in an ☐ Eyeglass Exam ☐ Contact Lens Exam ☐ Both ☐ Other Type of Exam _____

Do you have or have you had any of the following? If so, when were you diagnosed or treated?

☐ Cataracts _____ ☐ AMD _____ ☐ Retinal Hole/Tear/Detachment _____

☐ Glaucoma _____ ☐ Eye injury _____ ☐ Lazy Eyes _____

☐ Eye Infection _____

Lifestyle:

Do you have trouble driving? ☐ Yes ☐ No If yes, explain: _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, amount/how long: _____

Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis

Patient Signature/Date: _____

_____

_____