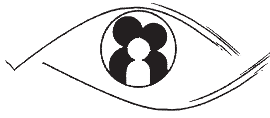

FAMILY EYECARE & CONTACT LENS CENTER LLC

Welcome to Our Office

Name ____________________

Street ____________________

City ____________ State ______ Zip ______

Home Phone ____________________

Cell Phones ____________ Ok to Text ❑ Yes ❑ No

Social Security Number ____________________

Employer ____________________

Employer Phone ____________________

Occupation ____________________

Hobbies ____________________

Email Address ____________________

Today's Date ____________ Date of Last Exam ____________

Name of Doctor who examined ____________________

Date of Birth ____________ Age ______ Sex: Male Female

What is the purpose of your visit today? ____________________

Spouse (or parent) name ____________________

Spouse (or parent) work phone ____________________

Vision Insurance: ❑ Medicare ❑ Medicaid ❑ VSP ❑ Blue Cross ❑ Flex Plan ❑ Other ____________

How will you settle your account today?

❑ Check ❑ Cash ❑ Credit Card ❑ Financing

List of other family members (spouse, children, etc.)
Mark boxes if patients of Family Eyecare Center

____________________ ❑
____________________ ❑
____________________ ❑
____________________ ❑
____________________ ❑
____________________ ❑
____________________ ❑

Diagnostic Issues

Please list any complaints about wearing glasses or contacts?

____
____
____

- Do you have more than 1 pr. of current Rx Glasses? No Yes
- Is there anything you would like to change about your current eyewear? No Yes
- Do you work on a computer for long periods? No Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? No Yes
- Do you feel the need for sunglasses? No Yes
- Are you interested in a "test drive" of the latest in contact lens design(s)? No Yes
- Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? No Yes

Do You Experience…

Any discomfort with your eyes? No Yes

Problems with glare or reflection? No Yes

Sensitivity to light? No Yes

Headaches? No Yes

Floaters or flashes of light? No Yes

How did you hear about our office?

❑ Friend or relative. Who? ____________
❑ Another health care practitioner. Who? ____________
❑ Yellow pages. Which directory? ____________
❑ Newspaper advertisement. Which paper? ____________
❑ Radio advertisement. Which station? ____________
❑ Previous patient. Who? ____________
❑ Participating eye care plan. ____________
❑ Other ____________