EYE CONTACT

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____
Last _____
First _____ MI_____
Street _____
City _____ State _____ Zip _____
Home Phone _____
Daytime Phone _____
SSN _____ Birth date _____ Sex M/F
Employer (or School): _____
Occupation (or Grade): _____
E-Mail Address _____

If patient is a minor (Under 18 or fulltime student)

Guarantor_____
Street _____
City _____ State _____ Zip _____
Home Phone _____
SSN _____ Birth date _____ Sex M/F

What is the major purpose of this visit?
_____

Any problems with your current contact lenses or glasses?
_____
_____

Who may we thank for referring you to our office?
_____

If not referred, how did you choose our office?

- ☐ Another Dr.
- ☐ Insurance List
- ☐ Saw Sign/Building
- ☐ Newspaper/Radio/TV
- ☐ Web Page: Which Web Site? _____
- ☐ Other _____

The doctors and staff of Eye Contact are fully committed to you and your families complete vision wellness. Our patients' visual needs are our highest priority. We are committed to providing state-of-the-art vision care, the finest eyewear products available in an atmosphere of uncompromised services, value, and friendliness.

Insurance Information

Vision Insurance _____
Insured Name _____
Insured ID# _____
Insured Birth Date _____
Patient relationship to insured
☐ Self ☐ Spouse ☐ Child

Primary Medical Insurance _____
Insured Name _____
Insured ID# _____
Policy Group # _____
Insured Birth Date _____
Patient relationship to insured
☐ Self ☐ Spouse ☐ Child

Do you participate in a flex spending account?
☐ Yes ☐ No

Lifestyle Questions

Do you….. (check box if your answer is yes)

- ☐ Work at a computer? How many hrs/day? ____
- ☐ Think you might benefit from thinner, lighter lenses?
- ☐ Have interest in a "test drive" of the latest contact lens designs
- ☐ Spend time outdoors? How much? ___Hrs/week
- ☐ Have prescription sunwear?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want information on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current RX eyewear?
- ☐ Have children?
- ☐ Have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Crossed eye/Eye turn
- ☐ Eye Infections
- ☐ Flash of light
- ☐ Glaucoma
- ☐ Headaches
- ☐ Itchiness
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Tearing
- ☐ Uncomfortable glasses
- ☐ Other eye disorders __ _____
- ☐ Burning
- ☐ Corneal Abrasions
- ☐ Double Vision
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Grittiness
- ☐ Irtis/Uveitis
- ☐ Lazy Eye
- ☐ Occasional dryness
- ☐ Sunlight Sensitivity
- ☐ Trouble seeing at night