Patient Information

Please Print Clearly **Date** ______________________________

______________________________ ______/______/______ ______ **Male / Female**
Name **Date of Birth** **Age**

______________________________ ______________________ ________ ______________
Current Street Address **City** **State** **Zip Code**

Home Telephone ( ) ______________________________ **Email** ______________________________

Work Telephone ( ) ______________________________ **Cell ( )** ______________________________

Employer ______________________________ **Occupation** ______________________________

Employers Address ______________________________

Emergency Contact ______________________ **Telephone #**______________ **Relationship** ____________

Your Primary Care Physician Name: ____________________ Phone____________________
Address: ______________________________
City: ______________________________

*We will be sending information regarding your health to your primary care physician.

HOW DID YOU HEAR ABOUT US / WHO REFERRED YOU?

________ Walking in the mall
________ Your Optometrist Name: ____________________City____________________

________ Your Primary Care Physician
________ Friend / Relative Name: ______________________________
________ Direct Mailing
________ Radio Station Which Station: ______________________________
________ Insurance Company ______________________________
________ Other Explain: ______________________________

Ocular History

What medications are you currently taking? ______________________________
Are you currently taking any eye medications? ______________________________
Carefully tell us about your allergies: ______________________________
How old are your current glasses? ______________ Years ______________ Months
How often does your prescription change? ______________________________

Do you wear contact lenses? Yes / No
If yes, What type? ____Soft daily ____Soft Toric _____Soft extended ____Rigid Gas Permeable
If you wear reading glasses, have you tried Monovision Contact Lenses? Yes No
How long have you worn lenses? ______How long ago did you remove them: _____wks ____days
Do you have a history of any eye surgeries? ______________________________