

# Welcome to our Practice

Please take a moment to complete this form. If you need help or have questions we would be happy to assist you. Please provide us with your insurance card. If you have VSP please provide us with the benefit holders full name and birth date as well as the last four of their social security number. Thank you!

## Patient Information

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
First Last MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer or School \_\_\_\_\_ Occupation or Grade \_\_\_\_\_

Spouse or Parent's name \_\_\_\_\_ Cell or work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ Previous Doctor \_\_\_\_\_

Name of general physician \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Work phone \_\_\_\_\_

## Reason for Visit

Please check all conditions that apply.

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Poor distance vision     | <input type="checkbox"/> Eye strain           | <input type="checkbox"/> Eye turn          | <input type="checkbox"/> Lazy eye      |
| <input type="checkbox"/> Poor near vision         | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Floaters of spots | <input type="checkbox"/> Eye infection |
| <input type="checkbox"/> Eyes burn, itch or water | <input type="checkbox"/> Dry eyes             | <input type="checkbox"/> Eye injury        | <input type="checkbox"/> Double vision |

## Medical History

Do you or anyone in your immediate family have a history of any of the conditions listed below? Check all that apply.

Self	Family member	Self	Family Member
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diabetes      Thyroid  
Cataracts      Heart condition  
Glaucoma      High blood pressure  
Blindness      Turned or lazy eye

Please explain any condition checked above \_\_\_\_\_

