

VisionCare Patient Information Form

Last Name _____ First Name _____ Date _____

Address _____
Street City Zip Code

Birthdate _____ Social Security # _____ - _____ - _____ Marital Status: S M W D

Telephone (H) _____ (W) _____ (Cell) _____

E Mail _____ Preferred Contact Method _____

Employer _____ Occupation _____

Referred By _____ Address _____

Responsible Party _____
(Name & Address If Different From Patient)

In Emergency Notify _____
(Name & Address If Different From Patient)

Do you wear glasses? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you wear contact lenses <input type="checkbox"/> Y <input type="checkbox"/> N
How long do you wear your glasses or contacts per day? _____ Hours	
How long have you had your present glasses or contacts? _____ Years	
How long has it been since your last eye examination? _____ Years	

Reason For Visit? _____

Blur at a distance?	Y	N	Blur at close up?	Y	N
Any allergies?	Y	N	Any eye pains?	Y	N
Any eye dryness?	Y	N	Any severe headaches?	Y	N
Any sinus problems?	Y	N	Any diabetes problems?	Y	N
Under a Doctor's care?	Y	N	On any medication?	Y	N

Have you ever had any eye injuries, infections, or surgery? Yes No
If yes, describe _____

Are there any major eye problems in your family? Yes No
If yes, describe _____

Do you now have, or previously had any serious health problems? Yes No
If yes, describe _____

Do you have any hobbies, sports, or activities that require special eye attention? Yes No
If yes, describe _____

Please check how you prefer to handle your account:

Cash/Check MC/Visa/Discover/AMEX Insurance

Our entire office is dedicated to providing you with the best possible vision care. I understand that I am ultimately responsible for payment of my account. We request payment at the time services are rendered unless arrangements are made in advance. I certify that the above information is true and correct.	
Signature _____	Date _____