Welcome

Patient Information

Thank you for choosing **Vision First** for your eye care needs. Please complete this form in ink. If you have any question or concerns, do not hesitate to ask for assistance. We are happy to help.

(Please Print)

Name_____ Age____ SS#_____ Date_____

Address_____City_____State____Zip_____

Birthdate _____ Sex _____ E-Mail Address _____

Home Phone #_____ Work Phone # _____ Cell Phone # _____

Do you prefer to receive calls at: □Home □Work □ Cell Phone

Are you: □Minor □Married □Divorced □Widowed □Single □Separated

You or your parent's employer_____Occupation _____

Business Address_____City_____State_____ Zip_____

Spouse's or parent's name_____Workplace_____Work phone #_____

If you are a student, name of school/college_____City_____State_____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____ Phone #_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient_____ Phone #_____

Address _____City_____State_____Zip_____

Name of employer_____ Work phone #_____

Vision Insurance Information

Name of insured_____ Relationship to patient_____

Address of insured (if different from above) _____

Birthdate _____ Insured's SS #_____

Name of employer _____ Work phone #_____

Address _____City _____State _____ Zip_____

Insurance Co._____ Group #_____ Member ID #_____

DO YOU HAVE MEDICAL INSURANCE? □No □Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured_____ Relationship to patient_____
Birthdate_____Social security #_____
Name of employer_____ Work Phone #_____
Address_____City _____State _____ Zip_____
Insurance Co._____ Group #_____ Member ID #_____

CONFIDENTIAL

HEALTH HISTORY

Reason for today's visit_____
Date of last eye examination_____ Name of previous eye doctor_____
Family Doctor _____
Are you interested in new glasses today? □ Yes □ No Are you interested in new contacts today? □ Yes □ No

Have you ever had any of the following conditions involving your eyes?

□ Eye surgery □ Sensitivity to light □ Eye infection or disease
□ Eye injury □ Floaters or spots □ Double vision
□ Flashes of light □ Eyestrain □ Severe pain
□ Burning, itching, or watering

Do you or anyone in your immediate family have a history of the following? If yes, please state who.

□ Diabetes □ Blindness □ High blood pressure
□ Thyroid □ Turned or lazy eye □ Macular degeneration
□ Glaucoma □ Heart condition

Please check any of the following conditions that apply to you:

□ Frequent headaches □ Drug allergies □ Pregnant
□ Allergies □ Sinus trouble □ Have given birth in the last 6 months

Please list all medications you are currently taking: _____

_____

_____

Please list drug allergies: _____

Do you currently wear glasses? □ Yes □ No

Have you ever worn contacts? □ Yes □ No

If so, what style?

□ Soft □ Extended Wear □ Gas Permeable □ Bifocal
□ Tinted □ Astigmatic □ Disposable □ Unsure

Do you work at a computer or video display terminal? □ Yes □ No

What hobbies or sports do you participate in? _____

X_____
SIGNATURE OF PATIENT (or parent if a minor) DATE