

NAME _____ DATE _____ TECH _____ DR _____
FIRST LAST

E-Mail Address _____

Please circle any of the following which may apply to your eyes:

- | | | | | |
|------------------|--------------------|----------------------|----------------------|---------------|
| Distance unclear | Near unclear | Eyes water | Eyes Tire | Redness |
| Burning | Irritated | Styes | Eye Strain | Eye pain |
| Grittiness | Itching | Sees spots | Headaches | Double vision |
| Dizzy spells | Sensitive to light | Haloes around lights | One eye turns in/out | Color Vision |

Please circle any of the following which you would like to discuss:

- | | | | | |
|--------------------------|--|--|-----------------------|-------------------------|
| Contact Lenses | Sport glasses | Computer Glasses | Safety glasses | No-line bifocals |
| Sunglasses | High-Index Thin lenses | Ultraviolet protective lenses | Self darkening lenses | Anti-reflective coating |
| Children's safety lenses | Ortho K (non-surgical correction of nearsightedness) | Vision therapy to improve reading skills | | |

What type of work do you do (occupation) _____ Hobbies _____

Do you use a computer? Yes No How many hours a day (average) _____

Are you planning to get new glasses today? Yes No Only if Rx changes

Do you wear contacts? Yes No What type? _____ Avg. wear per day? _____
Approx. years of wear? _____ Are you planning to get new contacts today? Yes No

Are you interested in finding out more about laser vision correction Yes No Maybe

Who is responsible for payment of account? _____

Method of Payment CASH CHECK CREDIT CARD INSURANCE COMBINATION
AUTOMATIC BANK/CREDIT CARD DEDUCTION

I acknowledge that I received a copy of the Notice of Privacy Practices. Date _____

PATIENT SIGNATURE _____

Form Completed by _____ Relationship to patient _____