



WELCOME TO THE PROFESSIONAL EYE CARE CENTER!

Title

Mr. Name _____
 Mrs. (Last)_____ (First)_____ (Middle)_____
 Ms. Address _____
 Dr. City/State/Zip _____
Telephone (Home)_____ (Work)_____
Age_____ Date of Birth_____ Sex Male Female
Employer_____ Occupation _____

Social Security Number _____

Referred by (We'd like to say thank you!)

In order to provide us with a better understanding of your vision care needs, please complete the following. (Please explain "Yes" answers)

1. Date of last eye examination _____
Dr.'s name _____ City/State _____
2. Date of last physical examination _____ Dr.'s name _____
3. Are you currently under a physician's care?..... Yes No
If yes, for what conditions?
4. Are you currently taking any medications?..... Yes No
If yes, please list:
5. Do you have (circle all that apply): Diabetes High Blood Pressure Fibromyalgia
High Cholesterol Cancer Rheumatoid Arthritis
6. Do you have any drug allergies?..... Yes No
7. Do you have any history of eye disease, injury, or surgery?..... Yes No
8. Do you have any family history of glaucoma?..... Yes No
9. Were your eyes "crossed" as a child or do you have a "lazy" eye?..... Yes No

☺ ☺ PLEASE COMPLETE THE BACK OF THIS FORM
☺ ☺

10. Are you having any problems with your vision (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Blurred close up vision | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Spots/floaters | <input type="checkbox"/> Itching | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Blurred distance vision | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Eye strain |

11. Do you now wear, or have you ever worn glasses?..... Yes No

If yes, how old is the prescription?

How is the prescription worn? Full Time Distance Vision Only Near Vision Only

12. Do you now wear, or have you ever worn contact lenses?..... Yes No

If yes, what type?

How many hours per day do you wear your contact lenses?

What is the name of your contact lens disinfecting system?

If you are not currently wearing your contact lenses, why did you stop?

13. Are you interested in any specific type of contact lens? (Please check box)

- | | | |
|--|--|---|
| <input type="checkbox"/> Soft | <input type="checkbox"/> Disposable | <input type="checkbox"/> Tinted |
| <input type="checkbox"/> Extended wear | <input type="checkbox"/> Gas Permeable | <input type="checkbox"/> 1-Day Disposable |
| <input type="checkbox"/> Astigmatic Soft (Toric) | <input type="checkbox"/> Bifocal | <input type="checkbox"/> Other |

14. Are you interested in learning more about Laser Vision Correction?..... Yes No

15. Please list your hobbies, sports, & special interests _____

Office Policy

It is customary to pay for all services as they are rendered.

Please be prepared to pay all co-payments today with cash, check or charge.

There is a \$25 billing fee if your exam co-payment is not paid today.

Professional fees are non-refundable. Spectacles and contact lenses are considered custom orders that have been prescribed by the doctor and are not transferable from one individual to another. Professional Eye Care Center will extend refunds and credits for these items based on manufacturers' warranties/credit policies and are subject to restocking fees.

Delinquent accounts are subject to a monthly service fee. There is a \$35 service charge on all returned checks.

SIGNATURE _____ DATE _____