

Visual-Eyes

Patient Information

Last Name : _____
First Name: _____
Middle Initial: _____
Mailing Address: _____

Zip Code: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Birthdate: ____/____/____
Employer: _____
Occupation: _____
SSN: _____
Vision Insurance: _____
E-mail address: _____
Primary Care Dr: _____

Guarantor Information

Last Name: _____
First Name: _____
Middle Initial: _____
Mailing Address: _____

Zip Code: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Birthdate: ____/____/____
Employer: _____
SSN: _____

Referred By: _____

Review of Systems

Are you currently being treated for:

Condition

Eyes _____
Ears _____
Nose _____
Heart _____
Lungs _____
Stomach _____
Genitourinary _____
Muscle _____
Skeletal _____
Skin _____
Neurological _____
Psychiatric _____
Hormonal _____
Blood _____
Allergic _____

Family History

Circle all that apply: Glaucoma Cataracts
Diabetes High Blood Pressure Macular
Degeneration

Medication/Medication Allergies

Meds: _____ Allergies: _____

Eye Surgical History

Areas of Interest

Contact Lens Wearer Yes/No/Interested
Laser Surgery Yes/No/Interested
Hobbies/Sports _____

Depending on the type of insurance, both dilation and contact lens examinations may or may not be covered by your insurance plan. We will inform you of any differences before proceeding with either dilation or a contact lens examination. **PAYMENT IS REQUIRED AT TIME SERVICES ARE RENDERED. GLASSES AND CONTACT LENS ORDERS REQUIRE 1/2 OF TOTAL PAYMENT TO START THE ORDER.**

SIGNATURE

DATE