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WELCOME TO OUR OFFICE

ADDITIONAL INFORMATION TO WEB FORM

PATIENTS NAME: _____ DATE OF EXAM: _____

SINGLE MARRIED OTHER DATE OF LAST EXAM: _____

IF CHILD PARENT OR GUARDIAN: _____ PHONE #: _____

ADDRESS IF DIFFERENT FROM PATIENT: _____

NAME OF PRIMARY INSURANCE HOLDER: _____

ID # OF PRIMARY INSURANCE HOLDER: _____ DATE OF BIRTH OF PRIMARY: _____

IS PRIMARY THE SAME FOR MEDICAL AND VISION? YES NO

IF NO AND A MEDICAL CLAIM GIVE NAME, DATE OF BIRTH AND ID #: _____

DOES PATIENT HAVE ANY OF THE FOLLOWING EYE SYMPTOMS?

ITCHING BURNING TEARING EYE PAIN HEADACHES BLURRED VISION

PLEASE EXPLAIN: _____

DOES PATIENT WEAR GLASSES? CONTACT LENSES

ARE YOU INTERESTED IN CONTACT LENSES? YES NO

WILL WE BE FITTING YOU WITH CONTACT LENSES TODAY? YES NO

ARE YOU INTERESTED IN LASER VISION CORRECTION? YES NO

**PLEASE SIGN BELOW THAT YOU REVIEWED THE INFORMATION ABOVE AND IT IS
CORRECT TO THE TO THE BEST OF YOUR KNOWLEDGE.**

SIGNATURE _____ DATE _____