Dr. Jay M. Wofchuck
Optometrist
3179 Hamner Ave #1
Norco, CA 92860
951-734-4802 *fax* 951-734-3035

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 _____