Check to see that all information is correct! **Pt ID**

*Salutation* *First* *MI* *Last* *Preferred Name*

*Street Address* *City* *State* *Zip*

*Date of Birth* *Home Phone - Include Area Code* *Work Phone* *Occupation*

*Spouse* *Name of Primary Care Physician* *Employer*

****Please present any insurance cards and forms.****

*Name of Insurance Company* *Insured's ID Number* *Employer of Primary Card Holder*

*Primary Card Holder's name* *Cardholder's DOB* *Name of secondary Insurance Company*

**Personal & Medical History**

| | | |
|---|---|---|
| Allergies | Yes | No |
| Arthritis | Yes | No |
| Diabetes | Yes | No |
| Asthma | Yes | No |
| Heart Disease | Yes | No |
| High Blood Pressure | Yes | No |
| Cancer | Yes | No |
| Eye Disease | Yes | No |
| Eye Surgery | Yes | No |

**Do you see clearly with your current glasses?**

| | | | |
|---|---|---|---|
| For TV | Yes | No | n/a |
| For Driving | Yes | No | n/a |
| For Computer | Yes | No | n/a |
| For Reading | Yes | No | n/a |

**Do you see clearly with your current contact lenses?**

| | | | |
|---|---|---|---|
| For TV | Yes | No | n/a |
| For Driving | Yes | No | n/a |
| For Computer | Yes | No | n/a |
| For Reading | Yes | No | n/a |

**If you wear contact lenses, are they comfortable?**
Yes No

**If you don't wear contacts, are you interested in being fit in contact lenses today?** Yes No

**How many hours per day do you look at the computer?**
0-3 4-7 Over 7

**Are you interested in having Lasik?** Yes No

**If this is your first time in our office, how did you hear about us?**

_____

**Do you participate in a flexible spending account (cafeteria plan) at work?**
Yes No

*THANK YOU FOR ASSISTING US IN TAKING BETTER CARE OF YOUR NEEDS.*