

WELCOME BACK TO OUR OFFICE

Today's Date _____

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Date of Birth _____ Age _____

Sex M F

Email Address _____

What is the major purpose of this visit?

Do you..... (check box if your answer is yes)

- Currently have problems with your glasses
- Prefer not to wear your glasses at times
- Have interest in trying one of the latest contact lens designs
- Have interest in a non-surgical approach to vision correction?
- Work at a computer? If yes, please complete computer questionnaire.
- Think you might benefit from thinner, lighter lenses?
- Have prescription sun wear?
- Spend time outdoors? How much? ___ _____ Hrs/week
- Want information on Laser Vision Correction surgery?
- Have more than 1 pair of current Rx eyewear?
- Have children?
- Have family members in need of eye care?
- Have any hobbies? If so, what _____
- Participate in any sports? If so, what _____

Name of Family Physician _____

Date of Last Physical Check-up _____

Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills) _____

Any allergies to medication? Yes No

If so, what medications? _____

Have you had any surgeries? Yes No

Have you been diagnosed or treated for any new health issues since your last visit, including allergies?

Yes _____ No _____

Change in insurance ___yes ___no

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Acuity Vision Care.

If your insurance company has not reimbursed our office in full within 60 days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.
Please note that Acuity Vision Care is not responsible for any overdraft fees.

CC#: _____

Expiration Date: _____

Signature _____