Please take a few minutes to complete this Patient Welcome Form before you visit our office for the first time. Print it out, fill it in, and bring the copy with you to your next appointment.

Complete Your Personal Information

Salutation ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss. ☐ Master ☐ Rev.

First Name* _____ MI _____

Last Name* _____

Preferred Name _____

Address _____ City _____

State _____ Zip _____

Home Phone _____ Work Phone _____

Phone Ext.: _____

Email Address* _____ Date of Birth(MM/DD/YYYY)* _____

Patient's Gender ☐ Male ☐ Female

Spouse/Parent Name _____ Guardian _____

Account Responsibility, if different from patient _____

Emergency Contact Name _____

Emergency Contact Number _____

How Found ☐ Phone Book ☐ School ☐ Ad ☐ Previous Patient

☐ Insurance Listing ☐ Drive By ☐ Other ☐ Doctor

Referred By _____

Complete Your Primary Insurance Information

Insurance Company _____

Insurance Address _____ City _____

State _____ Zip _____

Insured's First Name _____ Insured's MI _____

Insured's Last Name _____

Insureds Gender ☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____

Insured's ID _____ Group Number _____

Patients relationship to insured? ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Status ☐ Single ☐ Married ☐ Other

Patient's Employment Status ☐ Full Time Student ☐ Part Time Student ☐ Employed

Complete Your Secondary Insurance Information

Insurance Company

Insurance Address | City

State | Zip

Insured's First Name | Insured's MI

Insured's Last name

Insureds Gender ☐ Male ☐ Female | Date of Birth (MM/DD/YYYY)

Insured's ID | Group Number

Patient's relationship to insured? ☐ Self ☐ Spouse ☐ Child ☐ Other

Complete Your Primary Care Physician

First Name | MI

Last Name

Clinic Name

Address | City

State | Zip

Phone Number

Complete Your Referring Physician

First Name | MI

Last Name

Clinic Name

Address | City

State | Zip

Phone Number

Complete Your Health History

Main Reason for Exam?

Last Exam Date? (MM/DD/YYYY)

When was your last health exam?

Enter past illnesses or injuries

Past Surgeries?

Please list all medications or provide a list to the doctor

Please list all eye drops you are currently using

Please list any reactions or sensitivities you have experienced

Please list any specific allergies

Complete Your Eye History

Glaucoma	○ Yes	◉ No	Infection of Lid	○ Yes	◉ No
Cataract	○ Yes	◉ No	Itching	○ Yes	◉ No
Macular Degeneration	○ Yes	◉ No	Mucous Discharge	○ Yes	◉ No
Retinal Detachment	○ Yes	◉ No	Drooping Eyelid	○ Yes	◉ No
Color Blindness	○ Yes	◉ No	Redness	○ Yes	◉ No
Headaches	○ Yes	◉ No	Sandy or Gritty Feeling	○ Yes	◉ No
Glare/Light Sensitivity	○ Yes	◉ No	Blurred Vision Distance	○ Yes	◉ No
Tired Eyes	○ Yes	◉ No	Blurred Vision Near	○ Yes	◉ No
Lazy Eyes	○ Yes	◉ No	Crossed Eyes	○ Yes	◉ No

Burning	○ Yes	◉ No	Distorted Vision (halos)	○ Yes	◉ No
Dryness	○ Yes	◉ No	Double Vision	○ Yes	◉ No
Excess Tearing/Watering	○ Yes	◉ No	Floaters or Spots	○ Yes	◉ No
Eye Pain or Soreness	○ Yes	◉ No	Fluctuating Vision	○ Yes	◉ No
Foreign Body Sensation	○ Yes	◉ No	Loss of Vision	○ Yes	◉ No
Loss of Side Vision	○ Yes	◉ No			

Complete Your General Health Condition

Fever	○ Yes	◉ No	Muscles/Bones/Joints	○ Yes	◉ No
Weight Loss	○ Yes	◉ No	Skin	○ Yes	◉ No
Other Symptoms	○ Yes	◉ No	Neurological (i.e. Multiple Sclerosis)	○ Yes	◉ No
Ears/Nose/Throat	○ Yes	◉ No	Anxiety or Depression	○ Yes	◉ No
Heart conditions (i.e. high blood pressure)	○ Yes	◉ No	Thyroid/Diabetes	○ Yes	◉ No
Respiratory (i.e. Asthma)	○ Yes	◉ No	Blood/Lymph (cholesterol)	○ Yes	◉ No
Gastrointestinal	○ Yes	◉ No	Allergic	○ Yes	◉ No
Kidney	○ Yes	◉ No			
Are you?	☐ Pregnant	☐ Nursing			

Complete Your Family History

Amblyopia (Lazy Eye)	○ Yes	◉ No	Cancer	○ Yes	◉ No
Blindness	○ Yes	◉ No	Diabetes	○ Yes	◉ No
Cataract(s)	○ Yes	◉ No	Heart Disease	○ Yes	◉ No
Color Blindness	○ Yes	◉ No	High Blood Pressure	○ Yes	◉ No
Glaucoma	○ Yes	◉ No	Kidney Disease	○ Yes	◉ No
Macular Degeneration	○ Yes	◉ No	Lupus	○ Yes	◉ No

Retinal Detachment	○ Yes	● No	Stroke	○ Yes	● No
Strabismus (i.e. Eye Turn)	○ Yes	● No	Thyroid Disease	○ Yes	● No
Arthritis	○ Yes	● No	Others	○ Yes	● No

Complete Your Spectacle Lens History

Do you use a computer? ○ Yes ● No

How many hours/day? [ ]

Distance from Computer? [ ]

Do you drive? ○ Yes ● No

Mileage to work each way? [ ]

Do you have glare problems? ○ Yes ● No

Do you have visual difficulty when driving? ○ Yes ● No

Do you have problems with night vision? ○ Yes ● No

Do you currently wear glasses? ○ Yes ● No Since? [ ]

Type of glasses? ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned? ○ SingleVision ○ Bifocals ○ Trifocals ○ Backup Glasses ○ Safety ○ Sports ○ Progressive

Have you had trouble with glasses in the past? ○ Yes ● No Reason: [ ]

Do you wear sunglasses? ○ Yes ● No

Are your sunglasses your current prescription? ○ Yes ● No

Special eyewear needs?
- ☐ Computer (special prescriptions, special anti-glare tints or coatings)
- ☐ Occupational (mechanics, plumbers, pilots)
- ☐ Safety Glasses (gardening, woodworking, welding)
- ☐ Sports/Hobbies (racquet sports, motorcycle)

Complete Your Contact Lens History

Do you currently wear contact lenses? ○ Yes ● No Since? [ ]

If not a contact lens wearer, are you interested in trying contact lenses at this time? ○ Yes ● No

Have you ever tried to wear contacts? ○ Yes ● No

If yes, what was the reason for stopping? [ ]

Type and brand of contacts? [ ]

Today's wearing time?

How many hours/day?

How many days/week?

Please rate the following on a scale of 1-10 with 1 being POOR and 10 being EXCELLENT.

Lens Comfort	Right		Left	
Distance Vision	Right		Left	
Near Vision	Right		Left	

What solutions do you use?

Disinfectant used?

Enzyme used?

Complete Your Social History

Current occupation

Years?

Employer Name

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol? If yes - how often? ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke? If yes - how much/often ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake? ○ Smoking ○ Chewing

Do you use Illegal Drugs? ○ Yes ○ No

List your hobbies

Thank you for completing the Welcome Form information, we will be able to provide you with the best evaluation of your health using this information. We look forward to seeing you soon!

Signature:_____