

Patient Registration Form

Personal Information

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Patient's Occupation: _____

Home Phone: _____ Work Phone: _____

Name of Insurance Company: _____

Primary Insurance Holder: _____

Reason for Visit: _____

Optical History

Date of last eye exam: _____ Are you a new patient? Yes No

Have you worn glasses/contact lenses before? Yes No

How often? Full Time Part Time Interested in laser vision correction? Yes No

Please check all that apply

I Often Experience:

Eyestrain

Headaches

Bluriness at a Distance

Bluriness up Close

Discomfort

Double Vision

Glare

Light Sensitive

Vision Requirements:

Home and Office Use:

Computer

Reading

Desk Work

Outdoor Use:

Night Driving

Sports

Fishing

Medical History

Are you in good general health? Yes No If No, please explain: _____

Do you have a family history with any of the following:

Diabetes

Cataracts

Glaucoma

Retinal Injuries

High Blood Pressure

Macular Degeneration

Please explain any checked boxes above: _____

Are you currently taking medication or undergoing medical treatments? Yes No

Please list any medications: _____