

This Patient Information form is provided for your convenience. Please print the form, complete it, and bring it with you to the clinic.

PATIENT INFORMATION

Date _____

Name _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____

E-Mail Address _____ Age ____ Sex ____

Occupation _____ Married/Single _____

Hobbies/Sports _____

Medications _____

Allergies _____

Have you ever worn glasses? _____ Contact Lenses? _____ Now wearing? _____

How did you hear about our office? _____

Children Only/Name of Parent or Guardian _____

Payment is required at the time services are rendered. Please do not ask us to extend credit or bill you.

Preferred Method of Payment: " Cash " Check " VISA " Mastercard " Discover

Primary Reason for Your Visit Today _____

"I choose to have my eyes dilated for a complete exam and understand my vision may be blurred or light sensitive for 6 hours.

" I choose not to have my eyes dilated and understand that only a portion of the retina will be examined.

"I would like to have the visual field analyzer test today.

SIGNATURE _____