WELCOME BACK TO OUR OFFICE

Today's Date ______________________________

Patient Information

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?
____
____

Any problems with your current contact lenses or glasses?
____
____
____

Our Mission at Family Focused Vision Care is to provide absolute, top quality vision care. What this means to us is that our patients can expect the most thorough eye health exam, the detailed patient education, honest guidance in eyewear selection from a wide array of high quality frames and overall genuine, excellent service. We want to have fun serving our patients' vision care needs as we enrich their lives and develop a relationship that will last a lifetime.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance______________________________
Subscriber Name______________________________
Subscriber SSN_________________________
Subscriber Birth Date___________________________

Primary Medical Insurance______________________
Subscriber Name______________________________
Subscriber SSN_________________________
Subscriber Birth Date___________________________

Do you participate in a flex spending account?
☐ Yes ☐ No
How will you settle your account today?
☐ Cash ☐ Check ☐ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)
- ☐ ..work at a computer? If yes, please complete computer questionnaire.
- ☐ ..think you might benefit from thinner, lighter lenses?
- ☐ ..have interest in a "test drive" of the latest contact lens designs
- ☐ ..spend time outdoors? How much? __Hrs/week
- ☐ ..have prescription sunwear?
- ☐ ..prefer not to wear your glasses at times?
- ☐ ..want information on Laser Vision Correction surgery?
- ☐ ..have interest in a non-surgical approach to vision correction?
- ☐ ..have more than 1 pair of current Rx eyewear?
- ☐ ..have children?
- ☐ ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision	☐ Burning
☐ Cataracts	☐ Corneal Abrasions
☐ Crossed eye/Eye turn	☐ Double Vision
☐ Eye Infections	☐ Eye Injury
☐ Flash of light	☐ Floaters/Spots
☐ Glaucoma	☐ Grittiness
☐ Headaches	☐ Iritis/Uveitis
☐ Itchiness	☐ Lazy Eye
☐ Macular Degeneration	☐ Occasional dryness
☐ Retinal Detachment	☐ Sunlight Sensitivity
☐ Tearing	☐ Trouble seeing at night
☐ Uncomfortable glasses	
☐ Other eye disorders______________________	