

Welcome to Our Office

So that we can help you best, please fill out both pages legibly and completely. Thank You!

Full Name _____	Today's date _____
Name you go by (if different) _____	Approximate date of last eye exam _____
Home address _____	Date of birth _____ Sex: M F
City _____ State _____ Zip _____	Social security number _____
Home phone ____ (____) _____	Employer (or School) _____
Work phone ____ (____) _____	Occupation (or Grade) _____
Cell phone ____ (____) _____	Emergency contact & phone _____
E-mail address _____	Marital Status (if applicable) _____

Name of Family Members at Home	Relationship	Age	Current Patient of Ours?	
			Y	N
			Y	N
			Y	N
			Y	N

Primary Care Physician _____	How will you settle your account today?
Physician address & phone number _____	<input type="checkbox"/> Debit <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card

Are you a member of an eye care plan and/or medical plan? Y N (if yes, circle your plan(s) below and sign to authorize benefits)

VSP Eye Med Superior Vision Davis Aetna BCBS Cigna Humana Medicare PHCS UHC Other _____

Primary Insured _____ Birthdate _____ SS# _____ Employer _____

I authorize the payment of any eye care benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by the eye care plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: _____ Date _____

Personal Medical History	How did you <i>first</i> hear about our office?																														
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Allergies/Asthma</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> <td style="width: 25%;">Eye Disease/Infection</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> </tr> <tr> <td>Arthritis</td> <td>Y</td> <td>N</td> <td>Eye Surgery</td> <td>Y _____</td> <td>N</td> </tr> <tr> <td>Cancer</td> <td>Y</td> <td>N</td> <td>Eye Injury</td> <td>Y _____</td> <td>N</td> </tr> <tr> <td>Diabetes</td> <td>Y</td> <td>N</td> <td>Heart Disease</td> <td>Y</td> <td>N</td> </tr> <tr> <td>High Blood Pressure</td> <td>Y</td> <td>N</td> <td>Other</td> <td colspan="2">_____</td> </tr> </table>	Allergies/Asthma	Y	N	Eye Disease/Infection	Y	N	Arthritis	Y	N	Eye Surgery	Y _____	N	Cancer	Y	N	Eye Injury	Y _____	N	Diabetes	Y	N	Heart Disease	Y	N	High Blood Pressure	Y	N	Other	_____		<input type="checkbox"/> Family, friend, or co-worker. Who? _____ <input type="checkbox"/> Doctor referral. Who? _____ <input type="checkbox"/> Eye care plan directory. <input type="checkbox"/> Advertisement? _____ <input type="checkbox"/> Internet. Which website? _____ <input type="checkbox"/> Other. Please specify. _____ _____
Allergies/Asthma	Y	N	Eye Disease/Infection	Y	N																										
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Diabetes	Y	N	Heart Disease	Y	N																										
High Blood Pressure	Y	N	Other	_____																											
Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)	<p>Do you currently (or in the past), smoke, use alcohol, or narcotics?</p> <p>Y N</p> <p>If yes, please explain:</p>																														
Are you allergic to any medicines? Y N (If yes, please list)																															

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Family Medical History			
If yes, PLEASE SPECIFY	(mother, father, etc.)		
Diabetes	Y	N	Unsure
High Blood Pressure	Y	N	Unsure
Cataracts	Y	N	Unsure
Glaucoma	Y	N	Unsure
Macular Degeneration	Y	N	Unsure
Blindness or Visual Disability	Y	N	Unsure
Other disease (please specify) _____			

Eye Care for Your Lifestyle			
Do you desire glasses that are thinner, lighter, and more comfortable?	Y	N	
Do you spend much time outdoors?	Y	N	
Do you spend much time working on a computer?	Y	N	
Are your eyes very sensitive to bright lights?	Y	N	
Are you bothered by glare and reflections, especially at night?	Y	N	
Are you interested in wearing the most advanced contact lenses?	Y	N	
Current contact lens brand & prescription _____ Right _____ Left _____	N/A		
Are there times you would rather not wear glasses or contact lenses?	Y	N	
Do you suffer from dry eyes?	Y	N	
If you wear prescription glasses, do you have only one pair?	Y	N	N/A
If you wear bifocal glasses, does the line bother you?	Y	N	N/A
If you wear bifocal or progressive glasses, do you ever wish you could wear contacts?	Y	N	N/A
So that we can get to know you better . . . What hobbies, sports, or other activities do you enjoy?			

I acknowledge that I have received a copy of Dr. Kim's <i>Notice of Privacy Practices</i> , available from our office receptionist. You can also review it on our website, www.customeyesfrisco.com .	
Patient name _____	Today's Date _____
Signature of patient (or parent/guardian for minors) _____	

Thank you!