

**Baymeadows Vision Center  
Dr. Brian Armitage**

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex: M F  
What is the major purpose of this visit?  
\_\_\_\_\_  
\_\_\_\_\_

Spouse (Parent's name if minor) \_\_\_\_\_

**WELCOME TO OUR OFFICE**

(Please print)

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Email address \_\_\_\_\_

Social Security number \_\_\_\_\_

Employer (or school) \_\_\_\_\_

Vision Insurance \_\_\_\_\_

Member Name \_\_\_\_\_

Member ID (SS #) \_\_\_\_\_

Member DOB \_\_\_/\_\_\_/\_\_\_

Medical Insurance \_\_\_\_\_

Member Name \_\_\_\_\_

Member ID (SS #) \_\_\_\_\_

Member DOB \_\_\_/\_\_\_/\_\_\_

I authorize my insurance benefits to be paid directly to BVC. I understand that I am financially responsible for deductibles and any balance not covered by my insurance. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I acknowledge I received a copy of Baymeadows Vision Center Notice of Privacy Practices.

Signature of Patient or Legal Guardian (if less than 18) \_\_\_\_\_ Date \_\_\_\_\_

How will you be paying for today's visit?

Cash Check Credit

**Your Medical History**

Name of PCP \_\_\_\_\_  
 Arthritis Y N  
 Asthma Y N Diabetes Y N  
 Eye diseases Y N Heart Disease Y N  
 Eye injury Y N High Blood Pressure Y N  
 Eye surgery Y N Cancer Y N  
 Lazy eye Y N Headaches Y N  
 Cataracts Y N Breathing Problems Y N  
 Glaucoma Y N Nerves Y N  
 Any other medical condition \_\_\_\_\_

List current medications (Rx or Over the counter)  
 \_\_\_\_\_  
 \_\_\_\_\_

**How did you hear about our office?**

Current patient insurance list  
 Newspaper Yellow pages  
 New resident Office Sign  
 Other patient Other doctor

(Please write patient or doctor name)

May we use your name in thanking this person? Y N

**Do you**

- Work at computer for long periods? Y N
- Have more than one pair of glasses? Y N
- Want information on thinner, lighter lenses? Y N
- Have prescription sunglasses? Y N
- Have problems with glare or reflections particularly when driving at night? Y N
- Do you wear contact lenses? Y N  
Brand \_\_\_\_\_
- Do you want a contact lens exam to update your contact lens prescription? Y N
- If not currently wearing contact lenses, are you interested in wearing? Y N
- Are you interested in seeing without glasses, daytime contact lenses, or surgery? Y N
- Are you interested in laser vision correction? Y N

**Do you currently experience(circle all that apply)...**

Blurry distance vision / blurry near vision / headaches  
 Eye strain / trouble seeing at night / uncomfortable contacts  
 uncomfortable glasses / red eyes/ dryness / gritty feeling  
 watery eyes/ floaters / flashes of light /sensitivity to light