Welcome to Our Office!

Please fill out the information below as completely as possible.

First Name: ______________________ MI: ___ Last Name: __________________________ Suffix: _____

Nickname: ________________ Employer:__________________ Job Title:______________________

Address: ____ Apartment or Unit Number: ___________

City:_________________________________ State: ____ ZIP: _________ Marital Status: _____________

Cell Phone: _________________ Home Phone: ______________ Social Security Number: _____________

Email: ____ Date of Birth: ______________ Gender: M F

(Please Check one) Ethincity__ Hispanic/Latin __ Native Hawaiian/Other Pacific Islander__ Non-Hispanic__Decline to specify

Preferred Language:______________ Race:__________

Preferred Method of Contact: ________________

Vision Insurance (Policy Holder's) Name:________________________________

Date of Birth:_____________ Social Security Number:_____________________

Your Medical History

Primary Care Physician: _____________________

Arthritis:	Y	N	Asthma:	Y	N
Diabetes:	Y	N	Eye Diseases:	Y	N
Eye Injury:	Y	N	Heart Disease:	Y	N
Eye Surgery:	Y	N	Cancer:	Y	N
Lazy Eye:	Y	N	Headaches:	Y	N
Cataracts:	Y	N	Glaucoma:	Y	N
Anxiety:	Y	N			

Breathing Problems: Y N

High Blood Pressure: Y N

Do you currently smoke? Y N

Do you occasionally drink? Y N

Height: _____ Feet, ______ Inches

Weight: ________lbs

Current Medical Conditions: __________________

____

Current Medications: _______________________

____

Your Vision History

How many hours daily are you on the computer? _____

How old are your current glasses? _______________

Do you have more than one pair of glasses? Y N

Do you have outdoor glasses? Y N

Are your eyes sensitive to light? Y N

Do you wear contact lenses? Y N

Which lenses? ___________________________

Do you want a contact lens exam to update your contact lens prescription? Y N

If you do not wear contacts, are you interested in wearing them? Y N

Do you sleep in your contact lenses? Y N

How long do you wear each pair of lenses before disposing of them? ________________________

Are you interested in laser vision correction? Y N

Are you currently experiencing dry eye symptoms?

____

How did you hear about us? __________________

I authorize my insurance benefits to be paid directly to Baymeadows Vision Center. I understand that I am financially responsible for deductibles and any balances that are 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 that I have received a copy of Baymeadows Vision Center Notice of Privacy Practices.

Signature: ____ Date: ________________

Have you read the iWellness information provided? ☐ Yes ☐ No Employee Initial:______

Have you read the Contact Lens Evaluation information provided? ☐ Yes ☐ No Employee Initial: ______