Welcome to Our Office!

Please fill out the information below as completely as possible.

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

Nickname: _____ Employer: _____ Job Title: _____

Street: _____ Apartment or Unit Number: _____

City:_____ State: ____ ZIP: _____ Marital Status: _____

Cell Phone: _____ Home Phone: _____ Social Security Number: _____

Email: _____ Date of Birth: _____ Gender: M F

Race (Ethnicity) *(Check one or more boxes.)*
___American Indian/ Alaska Native; ___Black/ African American; ___Native Hawaiian/ Other Pacific Islander
___Hispanic or Latino; ___Asian; ___White; ___Decline to specify

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: _____