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) Ethnicity: __Hispanic/Latino __Native Hawaiian/Pacific Islander __Non-Hispanic __Decline to specify

Preferred Language: _____ Race: _____

Preferred Method of Contact: _____

Vision Insurance Policy Holder 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: _____