PATIENT RECORD
CONTACT LENS & VISION

(Please Print)

Patient Name: ☐ MR ☐ MRS ☐ MS _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Cell Phone ( ) _____ - _____

Occupation: _____ SS# _____

Date of Birth: _____ Age: _____ Email: _____

	YES	NO
Have you been examined here before?	☐	☐
Have you ever had a Dilated Eye Exam? If so, when?	☐	☐
Do you have frequent headaches?	☐	☐
Do you ever see double? (Two images, not just blurry)	☐	☐
Do you have dry eyes?	☐	☐
Do you see Flashing Lights or Floaters? (Circle which one)	☐	☐
Have you ever had an eye infection, injury or surgery?	☐	☐
Would you like information about Laser Vision correction?	☐	☐
Have you ever worn contact lenses?	☐	☐
Are you interested in contact lenses?	☐	☐

Personal Medical History

	YES	NO
High Blood Pressure	☐	☐
Diabetes	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Crossed/Lazy Eyes	☐	☐

Family Medical History

	YES	NO	(WHO?)
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Glaucoma	☐	☐	
Cataracts	☐	☐	
Crossed/Lazy Eyes	☐	☐	

List / Describe medications you are taking:

_____ _____ _____

_____ _____ _____

_____

List any Allergies:

_____ _____ _____

_____ _____ _____

_____

PAYMENT EXPECTED AT TIME OF SERVICE

I authorize the release of information to determine liability for payment and/or obtain reimbursement by Contact Lens and Vision. I understand that if my account is not paid in full, I am responsible for the remaining balance and/or full amount and will be billed of the outstanding balance.

X_____ _____

Signature **Date**