WELCOME TO LAGUNA CREEK OPTOMETRY

Family Vision Care

Last Name_____First Name_____
Spouse's Name_____
Street Address_____
City_____Zip Code_____
E-mail Address_____
Primary Contact Phone #(_____)_____Secondary #(_____)_____
Birthdate_____Sex_____Occupation_____
Whom may we thank for referring you to our office?_____

Financial arrangements for professional services and materials should be made at the time services are performed. It is the policy of this office that when materials are ordered, a minimum deposit of half of your account be paid, and the balance is due upon delivery of the materials.

Method of Payment: _____Insurance _____Check _____Cash _____Bankcard (Visa or MC)
Name of Insurance _____
Subscriber's ID# (usually SSN)_____

PATIENT HEALTH INFORMATION

1. What is the main purpose for visiting our office today?
   - _____Routine examination
   - _____Glasses need to be replaced
   - _____Contacts need to be replaced
2. Are you presently experiencing any of the following?
   - _____blurry distance vision
   - _____blurry near vision
   - _____eyestrain
   - _____headaches
   - _____flashes of light
3. Date of your last routine eye exam
   _____
4. Do you presently wear glasses?
   _____yes _____no
   If yes, _____full-time
   _____near _____far
5. Do you or any immediate family members have any of the following?
   - _____diabetes _____retinal disease
   - _____hypertension _____lazy eye
   - _____glaucoma _____blindness
   - _____cataracts
6. Have you ever had any of the following?
   - _____eye infections
   - _____eye diseases
   - _____eye surgeries, specify_____
   - _____laser therapy, specify_____
   - _____vision therapy (orthoptics)
7. Date of your last physical exam_____
8. Are you currently under the care of a physician?
   _____yes _____no
   If yes, for what conditions?_____
   _____
9. Do you currently take any prescription medications? _____yes _____no
   If yes, please list_____
   _____
   _____
10. Are you allergic to any medications? If yes, please indicate medication and reaction.
    _____
11. Do you presently wear contact lenses?
    _____yes _____no
    If yes, what type? _____gas permeable
    _____hard
    _____toric
    _____soft
    _____disposable
12. What is your wearing schedule with your contact lenses?
    - _____daily wear
    - _____extended wear
13. What brands of solutions do you use to clean your contact lenses?_____