EYE Styles for Lifestyles Optometry

Patient Information Form

Welcome to Eye Styles for Lifestyles. To help us serve you personally, please fill out the information requested below:

Personal Information

___Mr. ___Mrs. ____Ms. ____Miss ___Master ____Dr. e-mail _____

Name _____
First *Middle* *Last*

Address _____
Street *Apt.* *City* *State* *Zip*

Cell Phone (____) _____ Work Phone (___) _____ Date of Birth _____

Occupation_____ Company_____ Social Sec. _____

Vision Insurance _____ VSP _____ Medical Eye Services _____ Eyemed _____ Other _____

Were you referred to us? ___ Yes _____ No If yes, please check one: _____ Friend _____ Relative

Referral - Name_____

Otherwise, how did you hear about us? _____ saw sign _____ Yellow pages _____ insurance _____ internet

_____ eyestyles website _____ Google _____ other _____
(please specify)

Lifestyle Info

Vision demands at work

Closeup Work	_____ Mild	_____ Moderate	_____ Heavy
Driving (Day)	_____ Mild	_____ Moderate	_____ Heavy
Driving (Night)	_____ Mild	_____ Moderate	_____ Heavy

Do you wear safety glasses? Yes _____ No _____

Do you use a computer at work? Yes ___ No _____

Other workplace demands? Be specific _____

Vision Demands at Home

Do you play sports? If so, what sports? _____

What other hobbies/activities do you do? _____

Are you interested in: _____ **glasses** _____ **contact lenses** _____ **laser consult**
(check all that apply)

THANK YOU *for selecting our office to meet all your vision needs. We appreciate you filling out our Patient Information Form* ***completely****. Please give it to the staff when complete.*