



WELCOME TO OUR OFFICE! Thank you for selecting our office for your eye care needs. We recognize the trust and the responsibility placed in us and we will always strive to meet your expectations. Please let us know if there is anything we can do to make you more comfortable. We look forward to serving your eye care needs now and in the future.

Name: _____ Date of Birth: _____ SS#: _____
Address: _____ Home Phone: _____
City: _____ Zip: _____ Work Phone: _____ Cell Phone: _____
Occupation: _____ Employer: _____
Email (for notification of orders/appointment reminders): _____
Are you the primary insured? Yes No If No, name of primary: _____ Relation: _____
SS# of primary: _____ Employer of primary insured: _____

Whom may we thank for referring you? Friend Family Physician
Name: _____ May we send a thank you note? Yes No
Have we seen members of your family? Yes No
Whom? _____ Relation to you: _____
Whom? _____ Relation to you: _____

Please answer the following:
Primary reason for exam? _____
Blurred far away vision - without glasses/contacts? Y N - with glasses/contacts? Y N
Blurred near vision - without glasses/contacts? Y N - with glasses/contacts? Y N
Wear contact lenses? Y N If no, interested in contact lenses? Y N
Ever had an eye injury? Y N
Ever had eye surgery? Y N
Fatigue/eyestrain during/after reading/computer use? Y N
Frequent headaches? Y N
Eyes get dry and/or burn? Y N
Frequently lose your place when you read? Y N
Have itchy eyes? Y N
See flashes of light? Y N
Have double vision (not blurred)? Y N
Current Medications: _____
Allergic to medications? _____

Name of physician and phone and/or city: _____
Do you or anyone in you family have (please check all that apply):
High blood pressure []No []Self []Family
High cholesterol []No []Self []Family
Heart disease []No []Self []Family
Diabetes []No []Self []Family
Thyroid disease []No []Self []Family
Cancer (or history of) []No []Self []Family
Glaucoma []No []Self []Family
Retinal problems []No []Self []Family
Other? _____
Do you smoke? Yes No
Alcohol consumption per day? _____
Females, are you pregnant? Yes No

I am the patient, or the parent/legal guardian of the patient. I authorize payment to Cy Fair Vision Care directly from my insurance, and also authorize the physician and/or staff to release any information needed in the processing of any claims. I authorize the use of this signature on all insurance submissions. I understand I am financially responsible for all charges incurred during the course of this visit, including those not covered by my insurance. I understand there is a \$25 return check fee and finance charges may apply.

Patient/Guardian Signature Date Printed name of parent/guardian