Date_____

WELCOME TO OUR OFFICE
Please Print

PATIENT'S NAME_____SEX M___ F___ BIRTH DATE_____

IF MARRIED, NAME OF SPOUSE_____

IF CHILD, NAME OF PARENT_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE _(_____)_____WORK PHONE _(_____)_____

EMPLOYED AT_____OCCUPATION_____

SOCIAL SECURITY NUMBER_____INSURANCE_____

NAME AND LOCATION OF PRIMARY CARE DOCTOR_____

***If you would like our office to file insurance for your reimbursement, please allow front desk to make a copy of your insurance card

DATE OF LAST EXAM_____BY WHOM_____

REASON FOR TODAY'S VISIT (other than routine eye exam)_____

_____CONTACT LENS FITTING?_____

HOW WERE YOU REFERRED TO OUR OFFICE?

____FRIEND – WHO?_____ ___INSURANCE_____

____FAMILY – WHO?_____ ___VISION PLAN_____

____INTERNET/WEB SITE (NAME)_____ ____YELLOW PAGES ____OUR SIGN ___WORK

____ADVERTISEMENT_____ ____OTHER_____

HEALTH INFORMATION:

PERSONAL:

____ MEDICATIONS -- LIST:_____

____ MED ALLERGIES -- LIST:_____

____ HYPERTENSION _____DIABETES _____TUMORS/MALIGN ____EYE DISEASES

FAMILY: ____ GLAUCOMA ____ DIABETES ____ HYPERTENSION

____ RETINAL DISEASES (Macular Degeneration, Retinal Detachment, etc.)

COMPUTER WORK: HOURS PER DAY_____

DO YOU HAVE COMPUTER GLASSES?_____

DO YOU HAVE PRESCRIPTION SUNGLASSES?_____

HAVE YOU EVER TRIED CONTACT LENSES?_____WERE YOU SUCCESSFUL?_____

HOBBIES:_____

SPECIAL VISUAL REQUIREMENTS_____

****

DO YOU HAVE A PROBLEM WITH BEING DILATED IF DR. BLACKSTOCK RECOMMENDS IT? ____YES _____ NO

SIGN HERE TO RELEASE MEDICAL INFORMATION FOR INSURANCE **X**_____

Dr. Blackstock will be glad to release your contact lens prescription after your fitting is complete and your balance is paid. Georgia law states that all contact lens prescriptions expire one year from date of exam.