Peters Family Eyecare

WELCOME TO OUR OFFICE!

Please complete the following form as thoroughly as possible. The information in this confidential form is critical to the evaluation of your vision and eye health.

DATE: _____

First: _____ MI: _____

Last: _____

Preferred name: _____

Date of Birth: _____ Male / Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

How do you prefer to be contacted? Cirde two.

Home Cell Text Email

Patient's SSN: _____

Preferred language: _____

Ethnicity: _____

Employer/School: _____

Occupation/Grade: _____

Spouse/Parent's Name: _____

Spouse/Parent's Work: _____

HOW DID YOU HEAR ABOUT US?

Did someone refer you? If so, please tell us who so we can thank them! _____

If not, what made you call us? _____

Please let us know how your eyes have been doing/feeling since your last exam! Check all symptoms that apply.

- ☐ Blurry vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light Sensitivity
- ☐ Excessive tearing/watery eyes
- ☐ Tired eyes/eye fatigue
- ☐ Stringy mucous in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy/gritty feeling in the eye

DO YOU? Check all that apply.

- ☐ Work on computer or use a digital device?
- ☐ Spend time outdoors? If so approximately how many hours per day? _____
- ☐ Have glasses that protect your eyes from the sun?
- ☐ Prefer not to wear glasses at times?
- ☐ Have interest in a second pair?

Vision Insurance: _____

Subscriber Name: _____

Subscriber SSN/ID: _____

Subscriber Birthdate: _____

Medical Insurance: _____

Subscriber Name: _____

Subscriber SSN/ID: _____

Subscriber Birthdate: _____