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