Patient Information

Today's Date ____ / ____ / ____ Patient ID (office use only): _____

First Name _____ Last Name _____ MI _____ Nickname _____

Date of Birth _____ Age _____ Occupation _____

New Address _____City _____State ____ Zip _____

Home Phone _____ Cell Phone _____ Email_____

Emergency Contact |Relationship_____|_____ Phone_____

Would you like to receive appointment reminder/glasses or contacts pick up reminder via text message? ***Yes or No***

May we send a customer service survey to your email? ***Yes or No***

Reason for today office visit: □ Annual Eye Exam □ Glasses □ Contact Lens □ Medical Problem
□ Consultation □ Other _____

Would you like to get more information on the following? (Please check all that apply)

□ Daily Disposable Contact Lenses □ Color Contact Lenses □ Progressive Contact Lenses

□ Prescription Polarized Sunglasses □ Latisse for Eyelash Growth □ Restasis for Dry Eye

□ Diabetic Eye Exam □ Glaucoma Exam □ Sports Glasses □ Safety Glasses □ Computer Glasses

Current Medications? _____

Medical Conditions? _____

Allergies? _____

Dilation allows the doctor to examine the health of your eyes and detect certain conditions such as **cataract, glaucoma, tumor, retinal diseases, and vascular diseases.** These conditions and other ocular diseases may be **missed** if you do not dilate. *You will experience light sensitivity and **near** blurry vision after dilation*.

I (please circle one) **agree** or **do not agree** to be dilated:

Sign _____ Date ___ / ___ / ___

Digital Imaging Wellness Exam

- Sight-threatening eye diseases often have no outward signs or symptoms in the early stages.
- State-of-the-art technology allows the doctor to detect early signs of diseases such as glaucoma, macular degeneration, diabetic retinopathy, tumors, vascular diseases, and brain disorders, etc.
- Early detection and treatment of eye diseases may reduce your risk of vision loss.

The $29.00 charge is typically not covered by your vision or medical insurance, so this will be added into the cost of your visit today.

□ I **understand** the importance of this test and accept responsibility for the additional payment of $29.00 today.

□ I **decline** the importance of Digital Imaging Wellness Exam against medical advice.

Name _____ Date_____

Lifestyle Questionnaire

- How important is your vision to you? (Circle one)

1 Least	2	3	4	5 Most

- **Rank** the following in order of importance to you for glasses from 1 to 5 based on: (5 being most important)

Comfort	
Durability	
Style	
Hi-Definition Vision	
Cost	

- How long have you had your current prescription glasses? _____

- Do you notice scratches, smudges, fingerprints, and dust on your lens? Y or N

- Do you experience headaches, eye strain and/or blurry vision due to glare from headlights, sunlight, computer screens or fluorescent lights? Y or N

- Are you aware that sunlight UV rays cause the following:

  Eyelid/skin cancer Y or N

  Macular degeneration Y or N

  Cataracts Y or N

  Tissue mutation Y or N

Don't miss out on our current promotions!

- ***40% off complete second pair of glasses (frame and lens)***
- ***Buy an annual supply of contact lenses and receive 40% off complete pair of glasses (frames and lens)***
- ***25% off any non-prescription sunglasses***