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PATIENT INFORMATION FORM

ALL INFORMATION IS CONFIDENTIAL. WE NEED THE FOLLOWING INFORMATION TO SERVE YOU WELL. PLEASE PRINT

Patient Name _____ Sex M F

By what name do you prefer to be called _____

Street Address _____

City, State, Zip Code _____

Date of Birth ____/____/____ Social Security Number _____

Employer _____ Occupation _____

Phone Numbers: Home _____ Work _____ Cell _____

E-Mail Address _____

Marital Status: S M D W Spouse's Name _____

Please list immediate family members who are patients here _____

DO YOU HAVE ANY PERSONAL HISTORY OF THE FOLLOWING?

Cataracts	Y	N	Headaches	Y	N
Glaucoma	Y	N	Diabetes	Y	N
Lazy or Crossed Eye	Y	N	High Blood Pressure	Y	N
Eye Injury	Y	N	Heart Disease	Y	N
Eye Surgery	Y	N	Asthma	Y	N
Eye Pain	Y	N	High Cholesterol	Y	N
Depression/Anxiety	Y	N	Smoking	Y	N
Currently Pregnant	Y	N	Alcohol Use	Y	N

Current Medications _____

Allergies(including medication allergies) _____

Current family physician _____

Please describe any family history of eye or medical problems _____

Do you currently wear glasses?	Y	N
Do you currently wear contact lenses?	Y	N
Are you interested in contact lenses?	Y	N
Are you interested in laser vision correction?	Y	N

When and where was your last eye exam? _____

Main problem or reason for this visit? _____

Do you have any special requests? _____

If you need to leave by a certain time, please specify: _____

How did you find our office? Referral Yellow Pages Insurance List Advertisement Internet

Whom may we thank for referring you to us? _____

Method of payment today? Cash/check Visa/MC/Disc/AmEx Insurance _____

Release: I authorize Northwest Vision Center to release any information required for insurance processing. I understand that I am responsible for all charges and fees that my insurance does not pay.

Signature (Patient or Parent) _____ Date: _____