

WELCOME TO FAMILY FOCUSED EYECARE

Patient Information

Today's Date _____

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Date of Birth _____ Age _____

Sex M F

Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT!

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

Doctor Hulet and staff at Family Focused Eye Care commit to our patients to:

Provide our community with the highest standard of health care by utilizing state of the art technology and services.

Improve your quality of life to the greatest extent by preventative care and treatment; and managing all your vision needs.

Educate to ensure that you understand the value of uncompromised service. We are committed to making your eye care visit an experience of excellence.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

- Yes No

How will you settle your account?

- Cash Check Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sun wear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have an East/West commute?
- ..have more than 1 pair of current Rx eye wear?
- ..have children?
- ..have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

