Welcome Back to Our Office

FAMILY EYE CENTER
& Contact Lens Specialists

Name _____ **Date** _____

- **Please note if there have been any changes since your last visit.**

Address _____ Home Phone _____

_____ Work Phone _____

_____ Cell Phone _____

e-mail _____

- **I would like to see the doctor today for a/an:**

☐ Annual Eye Health Evaluation ☐ Annual Contact Lens Evaluation ☐ Medical Visit

☐ Lasik Consultation ☐LATISSE® ☐ Other _____

- **There are several ocular side effects from many of the commonly prescribed oral medications. Please list your current medications, including oral medications and eye drops.**

_____

_____

- **Have you had any changes in your Medical History and/or Surgeries since your last visit?**

_____

- **Since your last eye exam, have you suffered from:**

☐ Headaches ☐ Migraines ☐ Allergies ☐ Sensitivity to Light

☐ Dry Eyes ☐ Eye Strain/Pain ☐ Poor Vision at Night ☐ Problems with my Contacts

☐ Problems with my Glasses at Distance ☐ Problems with my Glasses at Near ☐ No changes

☐ Other _____

• Do you want to be evaluated for contact lenses today?	☐ No	☐ Yes
• Are you considering updating your eyewear today?	☐ No	☐ Yes
• Do you work on a computer for long periods of time?	☐ No	☐ Yes
• Do you spend a lot of time outdoors?	☐ No	☐ Yes
• Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy?	☐ No	☐ Yes
• Do you participate in any recreational sports?	☐ No	☐ Yes
• Did you receive a reminder card in the mail?	☐ No	☐ Yes

Please read and sign below.

Insurance may cover none or only part of your fees. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims, please give any forms to the receptionist. Family Eye Center, Inc. cannot bill insurance after services/products have been rendered.

X _____

SIGNATURE DATE