

Welcome to Santa Clara Vision Center

Patient Information Form, Please Print Clearly

Last name	First Name	Initial	Birthdate / /	Age	Today's Date / /
Address		City	State	Zip	
Children's Names	& Ages	If Child, Parent's Name	Spouse's Name		
Social Security #	Place of Employment or School	Type of Work or Grade in School			
Home Phone () - ()	Work Phone () - ()	Pager / Cell / E-mail (optional) () -			

How did you learn about our office and who may we thank?

Purpose of this appointment: (Annual exam, eye infection, Lost glasses, etc.) _____

Date of last eye examination _____

Do you wear glasses? Yes No

Do you wear prescription sunglasses? Yes No

Do you wear contact lenses? Yes No

If you wear contacts are your glasses current? Yes No

Have you ever worn contact lenses? Yes No

Are you interested in contact lenses for either full time, part-time, or occasional use? Yes No

Are you interested in **Laser Vision Correction** to reduce or eliminate the need for glasses or contacts? Yes No

Are you interested in **Non-Surgical Vision Improvement**?
Yes No

Do you use a computer at home or at work? Yes No
Aproximately how many hours per day? _____

Do you do much desk work, reading or writing? Yes No

Do you experience any eye strain, headaches or blurred vision while using a computer, or reading? Yes No

Do you experience any of the following symptoms?

- Dry eyes Eye aches or strain Watery eyes
 Red eyes Fluctuating vision Blurred vision
 Head aches Itchy/ burning eyes Sandy/ gritty eyes
 Trouble adjusting to glasses See spots or floaters

What activities do you enjoy? (check all the apply)

- Golf Tennis Fishing Walking
 Aerobics Skiing Biking Running
 Football Basketball Soccer Racing
 Playing musical instrument Other _____

Have you ever had an eye injury, surgery or disease?

Yes No Please describe: _____

Do you have a family history of any eye disease? (glaucoma, blindness, macular degeneration etc.)

Yes No Please describe: _____

Are you currently taking any prescription or non-prescription medications? Yes No Please list: _____

Do you have any allergies or are you allergic to any medications? Yes No Please list: _____

Any history of: Cigarettes Alcohol or Substance Abuse

Describe any current medical treatment, disease, conditions, pregnancies or other information the doctor should be aware of: _____

Your Physician's Name _____ Date last seen _____/_____/_____

Do you have vision insurance? Yes No
Name of insurance company _____

Do you have medical insurance? Yes No
Name of insurance company _____

Our office policy is to receive payment at the time of service
Payment will be made by:

- Cash Check Medicare
 VSP(vision service plan) Credit Card Other

We are happy to assist you in filing your insurance claim by giving you a **superbill** to submit for payment.

Thank you!

We want to thank you for selecting our office and for trusting us with your eye health and precious vision. We will strive to provide you with the best care possible.