WELCOME TO SANTA CLARA VISION CENTER

PATIENT INFORMATION FORM, PLEASE PRINT CLEARLY

Last Name:	First:		M.I.	Date:
Street Address:			Apartment/Unit #	
City:	State:	ZIP:	Date of Birth:	Age:
Social Security No.:	E-mail Address:			
Home Number:	Cell Number:		Work Number:	
Place of Employment or School:		Type of work or Grade in School:		
Children's name:	& Ages	If child parent's Names:		
		Spouse's Name:		

Preferred method of communication (E-mail, text, or phone etc.)?

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

Purpose of this appointment: (Annual exam, eye infection, lost glasses, etc.)?

Date of last exam? _____

Do you wear glasses? Yes No

Do you wear prescription sunglasses? Yes No

Do you wear contact lenses? Yes No

If you wear contact lenses are your glasses current? Yes No

Have you ever worn contact lenses? Yes No

Are you interested in contact lenses for 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

Approximately 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

_____Headaches _____Itchy/ burning eyes _____Sandy/gritty eyes

_____ Trouble adjusting to glasses _____See spots or floaters

What activities do you enjoy? (Check all that 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 medication?

Yes No Please list:_____

Do you have any allergies or are you allergic to any medication?

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 filling 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.