

Welcome! Thank you for your visit to Washington Square Eye Care. Please fill out this form completely so that we may better serve you and all your visual needs.

Patient Record

Please Print:

Name: Mr. Mrs. Ms. _____
Last First MI

Address _____
Street City State Zip

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Ext. _____ Cell # _____ - _____ - _____

Age _____ Date of Birth ____/____/____ Sex Male Female

Occupation _____ Employer/School _____

Hobbies / Sports _____

Do you have vision insurance? No Yes ---Carrier _____ Cardholder _____ ID# _____

Do you have medical insurance? No Yes --- Carrier _____ Cardholder _____ ID# _____

Social Security # _____ - _____ - _____ E-Mail Address _____

Age Of Current Glasses _____ Last Exam Date _____ By Dr. _____

Family Physician's Name _____ Referred to us by _____

Primary Reason for today's visit _____

When do you wear your glasses? Always For Distance For Near Sunglasses Never

Are you satisfied with your current glasses or contacts? Yes No If no, why not _____

Are you wearing or have you worn contacts? Yes No If yes, how long _____

Type now worn: Gas permeable Soft Overnight Wear Toric for Astigmatism Monovision Bifocal

Replacement Schedule Daily 2-Week Monthly 2-month Annually Other _____

Are you now interested in contact lenses? Yes No

Have you ever had any type of eye disease or surgery? Yes No If yes, explain _____

Is there any history of eye disease in your family? Yes No If yes, explain _____
Macular Degeneration, Glaucoma, Cataracts

Do you or any family member have Diabetes? Yes No If you then how long _____ Who else _____

Do have any current medical problems? Yes No If yes, explain _____

Are you currently taking medications? Yes No

Name _____ Purpose _____

Are You allergic to any Medications? Yes No Which ones _____

Are you interested in Laser Vision Correction? Yes No

Do you work on a computer Yes No If yes, how many hours per day? ____ at work ____ at home

Please check all that apply to you. Blurred Vision Frequent Headaches Dry Eyes Tired Eyes Itchy Eyes

Double vision Night vision problems Allergies Red Eyes

Method of payment: Cash Check Credit Card **Payment is requested when services are rendered or materials ordered.**

Please check all below and sign. I acknowledge that I have read Washington Square Eye Care's **Notice of Privacy Practices.**

I will be responsible for any deductibles, co-payments or other payments that are not met by my
Insurance or Medicare

Signature _____ Date ____/____/____