Farmington Vision Clinic

Date_____

__ Mr. __ Mrs. __Ms. __ Miss **Sex: __ M __ F**

Patient Name: _____ _____ _____
(First) (Middle) (Last)

Address_____ **Date of Birth** _____

City _____ **State** _____ **Zip** _____

Home Phone_____ **Work Phone**_____ **Cell Phone** _____

Social Security # _____ **what do you prefer to be called? (Nickname)** _____

Occupation: _____**Employed by:** _____

Last Examination by: _____**Have you worn contacts before?** _____

Are you taking any medications? _____

Are you using alcohol, tobacco or other substances? _____

Have you had a previous eye injury or disease? _____

DO YOU, OR ANY MEMBER OF YOUR FAMILY, HAVE ANY OF THE FOLLOWING PROBLEMS?

Diabetes __ You __Family	**High Blood Pressure** __You __Family	**Cataracts** __You __Family
Allergies __ You __Family	**Epilepsy** __You __Family	**Glaucoma** __You__ Family
Hay Fever __ You __Family	**Heart Condition** __You __Family	**Macular Degeneration** __You __Family
	Fainting Spells __ You __Family	**Other Eye Disease** __You __Family

RESPONSIBLE PARTY (if different from above)

Name of Person Responsible for Account _____

Relation to Patient _____ **Birthdate** _____ **Soc. Sec. #**_ _____

Address (if different from patient) _____

City_____ **State** _____ **Zip** _____ **Phone** _____

VISION INSURANCE INFORMATION

Vision Plan Name _____ **Phone** _____

Subscriber ID # _____ **Group** _____ **Effective date** _____

Subscriber's Name _____**Relation to Patient** _____ **Birth Date** _____

Subscriber Employed by _____ **Bus. Phone** _____

HEALTH INSURANCE INFORMATION

Many eye problems are covered by your Health Insurance

Health Plan Name _____ **Phone** _____

Subscriber ID # _____ **Group** _____ **Effective date** _____

Subscriber's Name _____ **Relation to Patient** _____ **Birth Date** _____

Whom may we thank for referring you? _____