WELCOME TO WORLD VISION CENTER

I. PATIENT INFORMATION:

Last Name________________________ First Name_______________________________

Address____

City: _____________________________ State: ____ Zip Code: ________________

Phone: (primary) ___________________________ (secondary) _______________________________

Date of Birth_______________________ M F Age______

Social Security Number________-______-________ Is Patient a minor (under 18) Y N

If patient is a minor parent/guardian

Last Name_______________________ First Name_______________________

HOW DID YOU HEAR ABOUT US? ____

II. GUARANTOR INFORMATION: *Complete ONLY if using Vision Insurance accepted by this facility.*

Last Name________________________ First Name_______________________________

Address____

City: _____________________________ State: ____ Zip Code: ________________

Phone: (primary) ___________________________ (secondary) _______________________________

Date of Birth_______________________ Social Security Number____-______-_________

Name of Vision Insurance____

Is this exam for: GLASSES CONTACTS BOTH MEDICAL** LATISSE OTHER

If OTHER please specify: ____

***I acknowledge that this visit MAY be changed to Medical Office Visit at doctor's discretion following his/her findings. _______(initial)

When was your last eye exam? ____________

MEDICAL HISTORY: Please check which apply only to YOU

___Diabetes I ___Diabetes II ___High Blood Pressure ___High Cholesterol ___Thyroid

___Arthritis ___Cataracts (if removed, when :____________________________)

___Glaucoma (if being treated, by what doctor :___________________________________)

___Macular Degeneration ___Eye Injury: (type/ occurrence) ____________________________________

PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING AT THIS TIME (including birth control, anti-depressants and any eye drops)

Primary Care Physician____

Clinic Name____

Clinic Address____

Phone Number____

FAMILY HISTORY (Please Circle All Conditions that Apply in Your **Family** History):

CATARACTS GLAUCOMA BLINDNESS MACULAR DEGENERATION

OTHER EYE HEALTH CONDITIONS____

By signing below I acknowledge that payment is due at time of services rendered and there are no refunds for professional services rendered.

_______________________________________ ___________________________

Patient/Guardian Signature Date