WELCOME TO WALESBY VISION CENTER

Patient's Name: _____ Today's Date: ____/___/_____
☐Dr ☐Mr ☐Mrs ☐Ms ☐Miss

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

Patient's Date of Birth: _____ Age: _____ S.S.#: _____-_____-_____

Home Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (____)____-_____ Alternate Phone: (____)____-_____ Work Phone: (____)____-_____

E-mail Address: _____ Spouse/ Parent Name: _____

Employer/School: _____ Occupation/ Grade: _____

Have you or a family member been examined here before? Yes ☐ No ☐ If Yes, when? _____

How did you hear about us? _____ If referred, by whom? _____

When was your last eye exam? _____ Where/Doctor's name? _____

Reason for today's visit? _____

Do you wear glasses? Yes ☐ No ☐ If Yes, what for? ☐ Distance ☐ Near ☐ Computer ☐ Driving ☐ Sports ☐ Sunglasses ☐ Reading ☐ Other: _____

Do you wear contacts? Yes ☐ No ☐ If Yes, how many years? ____ Type: ☐ Hard ☐ Soft ☐ Disposable

What are your daily visual tasks? _____

Have you ever had any of the following? ☐ Eye surgery ☐ Eye infections ☐ Eye disease ☐ Trauma to the head/eyes

Do you have any of the following? ☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Cancer ☐ Other: _____

Do you or a family member have any history of seizures? Yes ☐ No ☐ If yes, who? _____

Family history of eye disease or lazy eye? Yes ☐ No ☐ If yes, who? _____

Family history of: ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Other: _____ If yes, who? _____
Please list any medications you are taking and what for: _____
_____

Please list all allergies including medications: _____

How would you like to receive your yearly vision reminders? ☐ By Email ☐ By Postal Mail
Your email will be used solely for the purpose of updating you about appointments.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.
METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ DEBIT ☐ MASTER CARD ☐ VISA ☐ DISCOVER

Click Below to Submit Form!