Patient Acquaintance Form

Date_____
Name_____
Address_____
City_____ State_____ Zip Code _____
Phone: Home_____Cell _____ Work _____
E-mail_____
Birthdate _____
Occupation or Grade_____
Employer or School _____
S.S. No. _____
Please check one: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouses Name or Responsible Party if Minor:
Name_____
Address_____
City_____ State_____ Zip Code _____
Phone: Home_____Cell _____ Work _____

Please check all boxes that apply:
How did you hear about us? ☐ Insurance ☐ Website ☐ Social Media ☐ Yelp
☐ Search engine ☐ Signage ☐ Mailing/Brochure
☐ Referred by _____
Do you wear vision correction?☐ Glasses (☐ Single vision ☐Progressive ☐ Bifocal ☐ Other)
☐ Contact Lenses (☐ Soft ☐ Hard (RGP) ☐ CRT ☐ Other)
☐ LASIK/PRK/ICL ☐ IOL (cataract surgery)
Please list:
Any eye conditions (ex: glaucoma, dry eye)_____
Any health conditions _____
Any current medications _____
Any allergies to medications_____
Any family members with eye diseases and condition _____
Last eye exam and Dr. name_____
Last physical exam and Dr. name_____
Please circle: Alcohol – Yes/Social/No | Smoking – Yes/No/Former | Illicit Drugs – Yes / No

Method of Payment: ☐ Cash ☐ Charge Card ☐ Check ☐ Medicare ☐ VSP