## Welcome back to Family & Pediatric Eye Care!

Patient's name:	Date of appointment:				
Address:	City:			Zip:	
Home phone:	Daytime phone:		Cell pho	Cell phone:	
Patient's DOB:	Employer or School:		Occupat	Occupation or Grade:	
Spouse or Parent's name:	Emergency contact:				
*please fill in		nsurance Information	on ng insurance (vision and	l/or medical)	
	Member's name:				
Member's contract number:					
Name of employer:					
I prefer to be contacted via:	text cell phone  No.  *a copy of the Notice of	on the bottom of the telephontice of Patient Priver Privacy Practices in	initial e-mail that you re ne ne e-mail acy s available upon request	ceive from us.	
I acknowledge that I understand the Signature:			•		
·	<u>Reason fo</u> <u>*ple</u>	r your visit to our o	ffice today pply		
<ul><li>□ poor distance vision</li><li>□ double vision</li><li>□ eyes burn/itch/water</li></ul>	□ eye injury	□ sensitivity to	ots   eye infection light   dry eyes  need glasses		
Do you currently wear glasses?	?	If so, ho	w often?		
Do you currently wear contacts	s? If so, what ty	pe?	Are you interested in be	ing fit for contacts?	
Do you currently wear sunglasses? Are you interested in sunglasses?				nglasses?	
	loctor will discuss these	changes with you	since your last visit plea during your appointmen	ase check the box below. The nt.	

Welcome back to our office. We appreciate your trust with your family's eye care needs. If there is anything we can do to make your experience at our office more enjoyable, please make our office staff aware.

Thank you!