Welcome to Oliver Opticians

Today's Date: _____ Date of Last Eye Exam: _____

Contact Information

Name: _____

Street: _____

City: _____ State: _____

Zip code: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Personal Information

Employer: _____

Name of your Insurance:

_____

Insurance ID or Social Security:

_____

D.O.B:___/____/_____SEX: Male ___ Female ___

Spouse/Parent Name and Phone #:

_____

Personal & Family Medical History

Circle all that apply:

Allergies	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Glaucoma	Yes	No
Heart Disease	Yes	No
Eye Injury	Yes	No
High Blood Pressure	Yes	No
Head injury	Yes	No
Are you pregnant	Yes	No

Are you currently under the care of a Physician? Yes No

Name of Physician: _____

Do you Experience...

- Any discomfort with your eyes? No Yes
- Problems with glare or reflection? No Yes
- Sensitivity to light? No Yes
- Headaches? No Yes
- Floaters or flashes of light No Yes

How did you hear about us?

- ☐ Friend or relative
- ☐ Another healthcare Practitioner
- ☐ Yellow Pages
- ☐ Newspaper Advertisement
- ☐ Director Mailer
- ☐ Another patient
- ☐ Participating eye care plan

Please provide us with a name of any of the referral sources checked above so we may thank them properly:

_____

_____

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