Patient Information Form

Welcome to Eye Styles. To help us serve you personally, please fill out the information requested below:

Personal Info

_____Mr. ____Mrs. ____Ms. ____Miss ____Master ____Dr. e-mail _____

Name_____
First Middle Last

Address_____
Street Apt. City State Zip

Hm. Phone(____)_____ Wk. Phone (____)_____ Date of Birth_____

Occupation_____ Company_____ Social Sec._____

Vision Insurance _____ VSP ____Medical Eye Services ____ Eyemed ____ Other _____

Were you referred to us? _____Yes _____ No

If yes, please check one _____Friend _____ Relative _____ Dr.

Referral- Name _____

Otherwise, how did you hear about us?

____ saw sign ____ yellow pages ____ insurance ____ internet ____ website _____ other _____
(please specify)

Lifestyle Info

Vision demands at work

Close up work _____ Mild _____ Moderate _____ Heavy
Driving (Day) _____ Mild _____ Moderate _____ Heavy
Driving (Night) _____ Mild _____ Moderate _____ Heavy
Do you wear safety glasses? _____ Yes _____ No
Do you use a computer at work? _____ Yes _____ No
Other workplace demands? Be specific_____

Vision demands at home

Do you play sports? If so what sports?_____

What other hobbies/activities do you do?_____

Are you interested in: _____ glasses _____ contact lenses _____ laser consult
(check all that apply)

THANK YOU for selecting our office to meet all your vision needs. We appreciate you filling out our Patient Information Form **completely**. Please give it to the staff when complete.