Welcome! Thank you for your visit to Washington Square Eye Care. Please fill out this form completely so that we may better serve you and all your visual needs.

Patient Record

Please Print:

Name: ❒ Mr. ❒ Mrs. ❒ Ms. _____ _____ _____
Last First MI

Address _____ _____ _____ _____
Street City State Zip

Home Phone _____- _____- _____ Work Phone _____- _____ - _____ Ext. _____ Cell # _____-_____-_____

Age_____ Date of Birth _____/_____/_____ Sex ❒ Male ❒ Female

Occupation _____ Employer/School _____

Hobbies / Sports _____

Do you have vision insurance? ❒ No ❒ Yes ---Carrier _____Cardholder_____ID#_____

Do you have medical insurance? ❒ No ❒ Yes --- Carrier _____Cardholder_____ID#_____

Social Security # _____- _____- _____ E-Mail Address _____

Age Of Current Glasses _____ Last Exam Date _____ By Dr. _____

Family Physician's Name _____Referred to us by _____

Primary Reason for today's visit _____

When do you wear your glasses? ❒ Always ❒ For Distance ❒ For Near ❒ Sunglasses ❒ Never

Are you satisfied with your current glasses or contacts? ❒ Yes ❒ No If no, why not _____

Are you wearing or have you worn contacts? ❒ Yes ❒ No If yes, how long _____

Type now worn: ❒ Gas permeable ❒ Soft ❒ Overnight Wear ❒ Toric for Astigmatism ❒ Monovision ❒ Bifocal

Replacement Schedule ❒ Daily ❒ 2-Week ❒ Monthly ❒ 2-month ❒ Annually Other_____

Are you now interested in contact lenses? ❒ Yes ❒ No

Have you ever had any type of eye disease or surgery? ❒ Yes ❒ No If yes, explain_____

Is there any history of eye disease in your family? ❒ Yes ❒ No If yes, explain _____
Macular Degeneration, Glaucoma , Cataracts

Do you or any family member have Diabetes ❒ Yes ❒ No If you then how long _____ Who else _____

Do have any current medical problems ❒ Yes ❒ No If yes, explain _____

Are you currently taking medications? ❒ Yes ❒ No

Name _____ Purpose _____

_____ _____

_____ _____

Are You allergic to any Medications? ❒ Yes ❒ No Which ones_____

Are you interested in Laser Vision Correction? ❒ Yes ❒ No

Do you work on a computer ❒ Yes ❒ No If yes, how many hours per day? ____ at work ____ at home

Please check all that apply to you. ❒ Blurred Vision ❒ Frequent Headaches ❒ Dry Eyes ❒ Tired Eyes ❒ Itchy Eyes

❒ Double vision ❒ Night vision problems ❒ Allergies ❒ Red Eyes

Method of payment: ❒ Cash ❒ Check ❒ Credit Card **Payment is requested when services are rendered or materials ordered.**

Please check all below and sign. ❒ I acknowledge that I have read Washington Square Eye Care's **Notice of Privacy Practices.**

❒ I will be responsible for any deductibles, co-payments or other payments that are not met by my Insurance or Medicare

Signature _____ Date _____/_____/_____