Weston Optical Co. Confidential Internal Patient Registration Form

Name: _____DOB_____

Address: _____

Email Address: _____

Mobile Phone: _____ text OK? _____ Home/Work Phone: _____

Last Eye Exam: _____ Occupation: _____

Vision History

Do you wear glasses? YES / NO If so, are they for: DISTANCE / NEAR / BOTH

How long have you been wearing glasses? _____ Do you wear contact lenses? YES / NO

How many yrs.? _____ What type of contacts? _____ How many hrs. /day? _____

Have you or any of your relatives (parents, siblings, grandparents, or children) ever had any of the following:

Glaucoma		Eye Injury		Thyroid Trouble	
Cataract		Amblyopia		Sinus Trouble	
Retinal Detachment		Eye Turn		Headaches	
Eye Surgery		Diabetes		Cancer	
Eye Disease		High Blood Pressure		Macular Degeneration	
Blind Eye		Heart Disease		Eye Pain	
Double Vision		Eye Patching		Sensitivity to Light	
Eye Infection		Allergies:			

Are you currently under the care of a physician for any medical condition? _____

If so, please explain_____

Please list all medications you are currently taking: _____

Do you regularly spend time on a computer? _____ How much time avg/day? _____

Main reason for your visit today: _____

_____

By signing below, I agree that I am financially responsible for payment of services provided to me. My signature below authorizes Weston Optical Co. to release the information necessary to facilitate the payment of medical claims. My signature below also acknowledges that I was offered/received a copy of my prescriptions.

Signature: _____Date: _____