Hopping Eye Associates, Ltd, LLP

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Reason for this visit: _____

_____

WELCOME TO OUR OFFICE

Today's Date _____ Date of Last Exam _____

Mr. Mrs. Ms. Dr. _____

Nickname _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex M ☐ F ☐

Home Phone (_____) _____

Work Phone (___) _____ Cell (___) _____

E-Mail Address _____

Social Security # _____ - _____ - _____

Employer (or school) _____

Occupation (or grade) _____

Spouse or Parent Name _____

Spouse or Parent work # (_____) _____

Please list other family members and their ages:

_____

_____

Medical Insurance: We will need a current card to copy.

Name of Plan _____

Primary member's name _____

Primary member's date of birth _____

ID# _____ Group # _____

Vision Insurance:

Vision Plan Name _____

Primary member's name _____

Primary member's date of birth _____

ID# _____

Do You....

...Drive?	Y	N
...Work at a computer for long periods?	Y	N
...Have emergency glasses?	Y	N
...Have prescription sunglasses?	Y	N
...Have computer/special use glasses?	Y	N
...Wear contact lenses?	Y	N

Type of contacts: _____

List hobbies, sports, activities _____

_____

_____

Are you interested in:

Contacts?	Y	N
Laser surgery?	Y	N
Vision training?	Y	N
Sports vision enhancement?	Y	N
Muscle efficiency enhancement?	Y	N
Perceptual / learning enhancement?	Y	N

Have you or a family member (living or deceased) had: (If so, please note relationship)

Blindness	Y	N	_____
Cataract	Y	N	_____
Crossed eye	Y	N	_____
Lazy eye	Y	N	_____
Glaucoma	Y	N	_____
Macular degeneration	Y	N	_____
Retinal detachment	Y	N	_____
Eye disease	Y	N	_____
Eye injury	Y	N	_____
Eye surgery	Y	N	_____

How did you hear about our office?

Friend or Relative? Who _____

Another health care provider? _____

Yellow pages? Directory name _____

Other _____