

# BROOKS EYECARE

## Patient Visual Information Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Age: \_\_\_\_\_ Patient's Birthday: \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Check One:

Single  Married  Widow  Separated  Divorced

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

(If student, please include grade, school and teacher)

What is the purpose of this appointment ?

Routine Visual Exam  Visual Discomfort  Other

If you chose 'Other', please explain below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you wearing any visual prescription at this time ? (Check One)  Yes  No

If YES, how old is the prescription ? \_\_\_\_\_ years

How long has it been since your last visual examination ? \_\_\_\_\_ years

By whom ? \_\_\_\_\_

Have you ever been examined by the Optometrists at this office before ?  Yes  No

Who referred you to the Optometrists at this office ?

Referrer's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who will be responsible for the financial aspect of this case ?

Person's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How will the financial aspect of this case be handled ? (check one)

Check  Cash  Credit Card  Other