

The Eye Works Optometry

Welcome To Our Office

Patient Information

Insurance Information

Name _____ M.I. _____ Vision Insurance _____

Street _____
 City _____ State _____ Zip _____
 Phone (H) _____ (W) _____
 Cell/Mobile _____ other _____
 E-Mail _____
 Occupation/school grade _____
 Parent/guardian (minors) _____
 Date of Birth _____ Age _____
 Sex Male / Female
 Last vision exam? _____
 Major reason for today's visit? Circle any or all
Glasses/ Contacts/ Laser Correction/ Eye health/ Wellness
 Other _____

Subscriber Name _____
 Subscriber SS# _____
 Subscriber Birth Date _____
 Primary Medical Insurance _____

 Subscriber Name _____
 Subscriber SS# _____
 Subscriber Birth Date _____

Any problems/complaints related to current glasses
 or contacts _____

Do you participate in a flex spending account _____

Very Important For New Patients!!!!!!

Who may we thank for referring you to our office?
 Name of friend or relative _____

If not referred, how did you choose our office?
 Another doctor - Insurance list - Walk in/
 Newspaper/ TV/ Radio/ Magazine - which one _____
 Yellow Pages - which directory? _____
 Other - _____

- Have you ever experienced, been diagnosed,
 or treated for any of the following:
- Blurred Vision Far/Near Burning
 - Cataracts Corneal abrasion
 - Crossed/ Turned Eye Double Vision
 - Eye infections Eye injury
 - Flashes of light Floaters/ Spots
 - Glaucoma Headache/Migraine
 - Gritty, sandy scratchy Iritis/Uveitis
 - Itchy eyes Lazy Eye
 - Macular degeneration Retinal Detachment

Personal- Lifestyle Questions

Do you.....
 Work at a computer? _____ # of hours _____
 Have an interest in contact lenses? _____
 Spend time outdoors: Very Little/ Moderate/ A lot
 Have current prescription sunwear: Yes/ No
 Want info on Laser Vision Correction: Yes/ No

- Have children? Ages: _____
- Chronic Dryness Sunlight Sensitivity
 - Tearing/ Watery eyes Trouble at night
 - Bothered by glare Eye surgery (explain)

At The Eye Works Optometry we believe in
 providing state of the art eye care with the
 latest in fashion eyewear and excellent service!

Patient Medical History

Patient Eye History

Name of Family Physician _____

Date of Last Medical Exam _____

Current Medications (including eye drops, homeopathic, BCP)

Allergic to any eye drops or meds? If so, what? _____

Have you been diagnosed or treated for any of the following?

- Allergies
- Arthritis
- Blood or Lymph Diseases
- Respiratory Diseases/Conditions
- Cholesterol elevated
- Diabetes
- Cancer
- Thyroid problems
- Skin conditions
- Herpes virus
- High Blood Pressure
- Kidney Disease
- Neurological Disease/ conditions
- Psychological conditions
- Other
- Neck or back pain - chronic

Please explain: _____

Thank you,
Dr. Craig Sultan

Name of Last Doctor _____

For your occupational and hobby needs, do your present glasses meet your needs? _____

Do you currently wear contacts? _____

Satisfied with the vision and comfort from your contacts? _____

Issues/problems _____

If you do not currently wear contacts have you tried them in the past? _____ Reason for stopping

Ever been told you could not wear contacts _____

Why? _____

Family Eye History

Is there someone in your family with any of these:
Who?

- Blindness _____
- Cataracts _____
- Corneal Disease _____
- Diabetes _____
- Glaucoma _____
- Macular Degeneration _____
- Crossed or Wall eyed _____
- Retinal Disease _____
- Lazy Eye _____

Please review and sign the HIPPA and Financial Responsibility Forms
And enter in our Monthly Drawing for \$150 gift Certificate

If you are happy with the care and services you receive from us, please tell others – ask about our refer a friend rewards plan- any of our staff can explain the program to you