

Dr. Lynn Burford

WELCOME BACK TO OUR OFFICE

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Ms Mrs Mr Dr

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Date of Birth _____ Age _____

Sex M F

Email Address _____

What would you like to be called? _____

Preferred contact number _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

Our mission is to provide the highest quality eye care and excellent customer service in a professional, friendly environment. We pledge to remain at the technological forefront of our profession, with the needs and concerns of each patient always being our first priority. Everything we do shall communicate this.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Lifestyle Questions

Do you.....(check box if your answer is yes)

..work at a computer?

..have interest in a "test drive" of the latest contact lens designs

..participate in outdoors sports or activities?

..have prescription sunwear?

..want information on Laser Vision Correction surgery?

..have more than 1 pair of current Rx eyewear?

Eye History

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

Blurry Vision

Burning

Cataracts

Corneal Abrasions

Crossed eye/Eye turn

Double Vision

Eye Infections

Eye Injury

Flash of light

Floaters/Spots

Glaucoma

Grittiness

Headaches

Iritis/Uveitis

Itchiness

Lazy Eye

Macular Degeneration

Occasional dryness

Retinal Detachment

Sunlight Sensitivity

Tearing

Trouble seeing at night

Uncomfortable glasses

Other eye disorders _____