WELCOME TO FAMILY EYECARE OF BRIGHTON!

Please take a few minutes to read and complete this information sheet. If applicable, please bring any eye drops or vitamins you are taking to your appointment.

Name Gender

Preferred Name Home Number Daytime Number

Date of Birth

Home Address City/State Zip

Vision Insurance Social Security #

How did you hear about our office? Referred by?

Date of last complete vision exam? Performed by?

Indicate the name(s) of the person(s) with whom the doctor may discuss the results of your eye examination.

Reason for today's visit?

Yes No Do you wear glasses currently?

Yes No Do you wear contact lenses? If yes, what type? Soft | Disposable | Toric | Gas Permeable

Yes No Have your eyes ever been injured?

Yes No Have you had severe or recurrent eye infections?

Yes No Have you had any eye training, therapy, or surgery?

Yes No Are you currently being treated for an eye disease or other problem?

Yes No Has a doctor ever noticed anything unusual about your eyes?

Yes No Do you spend a lot of time looking at a computer?

Please list any medications you are taking.

Please list any drug allergies.

Examination charges and co-pays are due in full the day of your evaluation. A minimum of 50% is due before we order glasses and/or contacts. Most insurance that covers a routine examination will not cover a contact lens examination in full. The patient is required to pay the difference. While we file insurance as a courtesy for our patients, that is our relationship is with our patients and not their insurance company. If a claim is denied, the patient is required to pay the denied amount.

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