DUBLIN FAMILY VISION CENTER PATIENT QUESTIONNAIRE

Patient Information

Patient Name: ________________________________
Date of Birth/Age: ______________________________
Gender (circle one): Male Female
Social Security Number: ________________________
Street Address: ________________________________
City, State, Zip: ________________________________
Home Phone: ________________________________
Daytime Phone: ______________________________
Cell Phone: _________________________________
Email Address: _______________________________

Marital Status: _______________________________
Name of Spouse: _____________________________
Parents' Names & Birth Dates (if under 18/student):
- Father: ____________________________________
- Mother: ___________________________________

Employer: ___________________________________
Occupation: _________________________________
How did you hear about us: ____________________

Insurance Information

Vision Insurance Company: ___________________
I.D. Number: ________________________________
Member's Name: _____________________________
Member's Date of Birth: _______________________
Member's Social Security #: ___________________

Medical Insurance Company: ___________________
I.D. Number: _________________________________
Member's Name: _____________________________
Member's Date of Birth: _______________________
Member's Social Security #: ___________________

Health Information (Explain any "yes" answers in space provided below)

When was your last eye exam? ____
When was your last physical exam? ____
Family Physician Information: Name: __________________________________
Address: ______________________________ Phone: _____________________________________
______________________________ Fax: ______________________________________

Y N Have you recently been ill?
Y N Have you recently been hospitalized?
Y N Have you ever had a serious eye injury?
Y N Are you currently taking any prescription or over-the-counter medications (including birth control)? Please list: ____
Y N Are you aware of any heart problems?
Y N Do you have high blood pressure?
Y N Do you have high cholesterol?
Y N Are you diabetic?
Y N Do you have any allergies? Please list: ______________________________________
Y N Do you have frequent headaches?
Y N Have you ever worn contact lenses?
Y N Are you interested in contact lenses?

(continued on back)

Family Medical History

Which family members? (list below)

Y N Is there a history of high blood pressure? ____
Y N Is there a history of diabetes? ____
Y N Is there a history of glaucoma? ____
Y N Is there a history of cataracts? ____
Y N Is there a history of macular degeneration? ____

Emergency Contact Information

Name: ____
Relationship to Patient: ____
Home Phone: ____________________________
Cell Phone: ____________________________
Work Phone: ____________________________

Signature and Acceptance of Financial Responsibility

By signing below, I acknowledge my understanding that verification of insurance is not a guarantee of payment and that any balance is the sole responsibility of the patient.

Signature: ____________________________________ Date: ____________________
Print Name: ____________________________________

Thank you for choosing Dublin Family Vision Center!