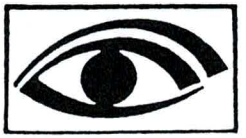

Dr. Gary J. Lake

OPTOMETRIST, P.C.

Welcome To Our Office

TODAY'S DATE_____

PATIENT'S NAME_____ DATE OF BIRTH_____
(LAST) (FIRST)

ADDRESS_____

_____ SOCIAL SECURITY #_____

EMAIL ADDRESS_____ CELL PHONE_____

HOME PHONE_____ WORK PHONE_____

PARENT'S OR GUARDIAN'S NAME_____

_____

EMPLOYER_____ POSITION_____ PHONE_____

SPOUSE'S EMPLOYER_____ POSITION_____ PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?_____

____FAMILY ____FRIEND ____PHONE BOOK ____ OTHER, EXPLAIN_____

_____

OTHER FAMILY MEMBERS, STILL LIVING AT HOME:

SPOUSE_____ AGE_____

NAME_____ AGE_____

NAME_____ AGE_____

NAME_____ AGE_____

NAME_____ AGE_____

PLEASE CHECK THE METHOD OF PAYMENT FOR TODAY'S PROFESSIONAL SERVICES:

____CASH ____CHECK ____CREDIT CARD ____INSURANCE (IF SO, WHAT TYPE?)

_____

Please fill out other side of this form

DATE OF LAST VISUAL EYE EXAM_____ EXAMINED BY_____

REASON FOR TODAY'S VISIT?_____

ARE YOU SENSITIVE TO LIGHT? ____ YES ____NO

____ FLUORESCENT LIGHTS ____ GLARE ____ SNOW ____ SUN

OCCUPATION_____ DO YOU WORK WITH A COMPUTER? ____ YES ____NO

HOBBIES OR SPORTS?_____

ARE YOU INTERESTED IN IMPROVING YOUR VISION WITHOUT GLASSES OR CONTACTS? ____ YES ____ NO

NAME OF FAMILY PHYSICIAN_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

____ ALLERGIES_____ ____HIGH BLOOD PRESSURE_____

____ DIABETES_____ ____ DRUG SENSITIVES_____

____ GLAUCOMA_____ ____HEADACHES_____

____ EYE SURGERY_____ ____ EYE DISEASE_____

_____ OTHER (EXPLAIN)_____

DOES ANY MEMBER OF YOUR FAMILY HAVE ANY OF THE ABOVE? (SPECIFY)_____

DO YOU SMOKE? ____ YES ____ NO

DO YOU CONSUME ALCOHOL? ____ YES ____ NO AMOUNT_____

DO YOU USE ANY NON-PRESCRIBED DRUGS? ____ YES ____ NO TYPE_____

WHAT MEDICATIONS ARE YOU PRESENTLY TAKING?_____

DO YOU FEEL YOUR GLASSES AND/OR CONTACT LENSES ARE FULFILLING YOUR VISUAL NEEDS?____ YES ____ NO