WELCOME TO OUR OFFICE

NAME First_____Middle_____Last_____
Name you prefer to be called_____ **male**_____ **female**_____

IF MARRIED, NAME OF SPOUSE_____
IF UNDER 21 PARENTS NAME_____
Social Security Number of Responsible Party_____

Patient DATE OF BIRTH_____OCCUPATION_____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE: _____ ALTERNATE # : _____

HOBBIES AND ACTIVITIES: (circle) CRAFTS READING SEWING
DESK WORK TYPING COMPUTER CARD PLAYING PIANO ORGAN MUSICIAN
GOLF FISHING HUNTING SWIMMING FLYING MACHINE OPERATION STUDYING
OTHER_____

WHEN WAS YOUR LAST EYE EXAMINATION_____BY WHOM_____
DO YOU WEAR GLASSES_____CONTACT LENSES_____OVERNIGHT_____
HAVE YOU HAD OR ARE YOU CONSIDERING "LASIK"_____
IS YOUR HEALTH GOOD, FAIR, OR POOR_____
ARE YOU DIABETIC_____WHAT MEDICINES ARE YOU ALLERGIC TO_____
DO YOU OR YOUR FAMILY HAVE A HISTORY OF EYE DISEASE_____
IS YOUR BLOOD PRESSURE HIGH, NORMAL, OR LOW_____
WHOM MAY WE THANK FOR REFERRING YOU TO US_____

INSURANCE INFORMATION:
INSURANCE NAME_____INSURANCE MEMBER_____
EMPLOYER OF MEMBER_____DOB OF MEMBER_____
MEMBER SS#_____ RELATIONSHIP TO MEMBER_____

I HAVE HAD AN OPPORTUNITY TO REVIEW "NOTICE OF PRIVACY PRACTICES"
SIGNATURE_____DATE_____

PLEASE LIST CHILDREN OF YOUR HOUSEHOLD THAT ARE PATIENTS OF KEARNEY VISION:
NAME:_____DATE OF BIRTH:_____
_____ _____
_____ _____

PRIMARY CARE PHYSICIAN**:** NAME:_____
PHONE:_____
ADDRESS:_____