



WELCOME TO OUR OFFICE

NAME _____ DATE _____ LAST EXAM _____ AGE _____

STREET _____ P.O. BOX _____ DATE OF BIRTH _____ M ___ F ___

CITY _____ STATE _____ ZIP _____ S.S # _____

HOME # _____ WORK # _____ CELL# _____ EMAIL _____

SPOUSE / PARENT NAME _____ SPOUSE/PARENT WORK # _____

EMPLOYER OR SCHOOL _____ OCCUPATION/GRADE _____

VISION INSURANCE _____ MEDICAL INSURANCE _____

**** IF YOU ARE ON MEDICAID OR PEACHCARE AND HAVE OTHER INSURANCE COVERAGE, PLEASE LET THE RECEPTIONIST KNOW.**

EMERGENCY CONTACT _____ PHONE # _____

MEDICAL HISTORY:

GLAUCOMA	YES	NO
CATARACTS	YES	NO
EYE INJURIES	YES	NO
EYE DISEASES	YES	NO
LAZY EYE	YES	NO
HEADACHES	YES	NO
DIABETES	YES	NO
HIGH BLOOD PRES.	YES	NO

FAMILY HISTORY (RELATIONSHIP)

GLAUCOMA	YES	NO
CATARACTS	YES	NO
DIABETES	YES	NO
HIGH BLOOD PRES.	YES	NO

CURRENT MEDICATIONS _____

CURRENT PHYSICIAN NAME _____

WHAT HOBBIES DO YOU ENJOY? _____

WHAT IS THE MAJOR PURPOSE OF YOUR VISIT? _____

HOW DID YOU FIRST HEAR ABOUT TILLMAN EYE CENTER? FRIEND _____, RELATIVE _____, REFERRED BY ANOTHER DR. _____, IF SO, WHO _____ YELLOW PAGES _____ OTHER _____

ARE YOU CURRENTLY WEARING GLASSES? YES NO CONTACTS? YES NO

ARE YOU INTERESTED IN CONTACTS? YES NO

DO YOU WORK WITH A COMPUTER? YES NO

ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH YOUR GLASSES OR CONTACTS? _____.

METHOD OF PAYMENT SERVICES: CHECK ___ CASH ___ CREDIT CARD ___ MEDICAID ___

WOULD YOU LIKE INFORMATION ON A NON-SURGICAL PROCEDURE TO REDUCE OR ELIMINATE THE NEED FOR GLASSES? YES NO