

McMILLIAN EYE CARE

Welcome To Our Office

Name: _____
Street: _____
P.O. Box: _____
City: _____ State: _____
Zip: _____ Phone: _____
Date of Birth: _____
Sex: Male Female
Social Security#: _____
Spouse: _____

Employer or School: _____
Work#: _____ Cell# _____
Occupation: _____

Today's Date: _____

Responsible Party, if other than patient
Name: _____
Address: _____
Phone: _____ Date of Birth: _____
Social Security#: _____

Vision Insurance: _____
Medical Insurance: _____
Primary Care Physician: _____
Address: _____
Phone: _____

- Have you ever worn or are you currently wearing contact lenses? Yes No
- Are you interested in contact lenses? Yes No
- Are you interested in information concerning laser vision correction? Yes No
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How did you first hear about our office?

- Referred by a friend or relative
If so who? _____
- Referred by another health care practitioner
If so who? _____
- Yellow Pages
- Newspaper Advertisements
- Radio
- Community Event
- Office Signs
- Insurance
- Mail
- Website
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- Other _____

Hobbies/Leisure Activities

- Arts & Crafts
- Boating
- Fishing
- Flying
- Golf
- Hunting/Shooting
- Racquetball
- Reading
- Sewing
- Skiing

- Do you have prescription sunglasses?