

Welcome to
Baker Vision Care

Patient Name: _____
Legal Guardian's Name (if applicable) _____
Address: _____
City: _____ State: ___ Zip: _____
Home #: _____
Work #: _____
Cell #: _____
Email Address: _____
Male or Female (circle one)
Date of Birth: _____
Social Security Number: ____-____-____
Married ___ Single ___ Divorced ___ Widowed ___ (check one)
Employment Status: Part ___ Full ___ Not Employed ___
Retired ___ Student ___ Disabled ___
Employer: _____
Job Title: _____
Who should we contact in an Emergency?
Name: _____ #: _____
Insurance: _____ Policy holder: _____
Policy Holders DOB: _____
Insured ID #: _____ Group #: _____
Drivers License #: _____ Exp: _____ State _____

~PLEASE TURN TO NEXT PAGE~

Medical History:

Primary Care Doctor: _____

Phone #: _____ Address: _____

Also list any other Dr. you may see: _____

Date of Last Physical: _____

(Please check what applies to you)

High Blood Pressure Depression

Diabetes Cancer (if so please list) _____

Acid Reflux _____

Asthma Anxiety

Headaches Allergies (seasonal)

High Cholesterol ADHD/ADD

Arthritis Thyroid

COPD (Chronic Obstructive Pulmonary Disease)

Please list any other conditions not listed above:

Please list all recent surgeries and the year they happened:

_____ Year: _____

_____ Year: _____

_____ Year: _____

Please list ALL Medications you are currently taking:

~PLEASE TURN TO NEXT PAGE~

Are you allergic to any Medications: _____
If so, what are they: _____

Do you have a family history of the following eye problems? (please list beside them who in your family has this)

Diabetes _____ Macular Degeneration _____
Glaucoma _____ High Blood Pressure _____
Retinal Detachment _____ Cataracts _____

How did you hear about our office? _____

Did you see our ad in the Home Town Journal? _____

Reason for today's visit? _____

Do you currently wear glasses? _____ Contacts? _____

Do you have them with you today? _____

Please Read and Sign:

I understand that if my insurance denies payment for any reason and I do not resolve the issue within 30 days, I become responsible for the full amount.

Signature: _____

Baker Vision Care

Your Lifestyle

Your answers to these questions will guide us in recommending the best products to meet your individual eyewear needs.

Name _____ Date _____

How long have you been wearing contacts? _____ glasses? _____

Are you planning to get new contacts or glasses today? Yes No

Do you wear prescription sunglasses? Yes No

Non-prescription sunglasses? Yes No

When do you wear glasses or contacts? Glasses Sunglasses Contacts

All the time

For reading/working

For driving

For sports and recreation

Other _____

What is your occupation? _____

Which of the following do you do regularly?

- | | |
|---|--|
| <input type="checkbox"/> Night driving | <input type="checkbox"/> Work outdoors (power saws, weed eater) |
| <input type="checkbox"/> Commute 20+ minutes by car | <input type="checkbox"/> Work with small objects |
| <input type="checkbox"/> Work under fluorescent light | <input type="checkbox"/> Read for long periods |
| <input type="checkbox"/> Work on a computer | <input type="checkbox"/> Weld or Grind |
| <input type="checkbox"/> Watch television 3+ hours | <input type="checkbox"/> frequently alternate between indoors and outdoors |
| <input type="checkbox"/> Work at a desk | <input type="checkbox"/> use firearms (shotgun, rifle, hand gun) |
| <input type="checkbox"/> Other _____ | |

List all sports and hobbies that you participate in _____

What do you like about your current glasses? _____

What features will be important in choosing your new glasses?

- | | |
|---|---|
| <input type="checkbox"/> Style | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Frame Material | <input type="checkbox"/> Lens type |
| <input type="checkbox"/> Fit | <input type="checkbox"/> Lens thickness |
| <input type="checkbox"/> Durability | <input type="checkbox"/> Lens color |