



Tell Us About Yourself

PLEASE PRINT

Date: ____/____/____ Birthdate: ____/____/____
M D Y Age: _____ M / F

Name: _____
(Last) (First) (MI)

Address: _____

City, State, Zip Code: _____

Phone Day: (____) _____ Evening: (____) _____

Cell: (____) _____ Email: _____

How would you prefer we contact you? _____

Occupation: _____ Employer: _____

Medical/Vision Insurance: _____ Medical ID # _____

Who is your current eye doctor? _____ Last Eye Exam (mo/yr): ____/____

Location: _____

How did you hear about Dr. Furlong? _____

Name of person who referred you: _____

To better understand your vision needs, please answer all questions (or N/A)

What is your motivation for vision correction? _____

How long have you been considering vision correction? _____

What is your timeframe for vision correction? _____

What concerns do you have about having vision correction? _____

Do you wear: Glasses? Contact Lenses? Readers/Bifocals? _____ # of years

Do your glasses/contacts interfere with recreational activities? Yes No

How? _____

Current Prescription (if known): Right: _____ Left: _____

List any current medical conditions (e.g. diabetes, pregnancy/nursing, autoimmune, tuberculosis): _____

List any medications you currently use (including eye drops): _____

Anything else we should know? _____

I have been informed of the Privacy Practices and Patient Bill of Rights and have received a copy.	
Patient Name (please print)	
Signature of Patient or Personal Representative	Date
If Personal Representative signs, please describe relationship: _____	

Spouse/Friend: _____