



Tell Us About Yourself

PLEASE PRINT

Date: ____ / ____ / ____ Birthdate: ____ / ____ / ____ Age: ____ M / F

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

Address: _____

City, State, Zip Code: _____

Phone Home: (____) _____ Office: (____) _____

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? _____

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:

For Office Use Only

Vision (aided) DVaccOD: 20 / DVaccOS: 20 / P_PACH <

Vision (unaided) DVascOD: 20 / DVascOS: 20 / HWTW <

Notes: _____

Spouse/Friend: _____