



Tell Us About Yourself

PLEASE PRINT

Date: _____ / _____ / _____ Birthdate: _____ / _____ / _____ Age: _____ M / F
M D YName: _____
(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)

Please indicate the reason for today's visit. (Check all that apply):

 Cataract Evaluation
 Glaucoma Evaluation
 Medical Eye Evaluation
 Keratoconus

How long ago were you informed that you had this eye condition? _____

What activities are particularly difficult now? (reading, computer work, driving, hobbies, etc.) _____

Do you have a timeframe for when you would like surgery? _____

If yes, when? _____

What concerns do you have about treatment? _____

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: _____