WELCOME TO JOY OPTOMETRY

Mr.	Mrs.	Ms.	Dr.

Suffix

First Name

Last Name

Birth Date (MM/DD/YYYY)

STREET

CITY STATE ZIP

Address

XXX - XX -

SSN of Insurance Primary Member
(last 4 digits only)

How did you find us?

- ☐ Yelp / Internet
- ☐ VSP listing
- ☐ Friend/Family

We **text** appointment reminders & glasses/contacts pick up notification.

We **email** prescriptions & referral copies.

Cell Phone Number

Email Address

Employer

Occupation

Guardian's Name (if under 18)

Main purpose of today's visit:

- ☐ Periodic check up
- ☐ Other:

Most recent visual examination

Date:
Doctor name:

Do you experience any of the following?

- ☐ Blurry far vision
- ☐ Blurry near vision
- ☐ Double vision
- ☐ Floaters
- ☐ Dry eyes
- ☐ Watery, itchy eyes
- ☐ Redness
- ☐ Light sensitivity
- ☐ Flashes of light
- ☐ Headache

Do you have a history of the following?

- ☐ Cataracts
- ☐ Amblyopia / lazy eye
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Strabismus / crossed eye
- ☐ Retinal problems
- ☐ Eye infection
- ☐ Eye surgery
- ☐ Eye trauma
- ☐ LASIK **(date:**)

Have you been treated for any of the following?

- ☐ Diabetes
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Thyroid
- ☐ Arthritis
- ☐ Others not listed:
- ☐ Stroke
- ☐ Skin disorders
- ☐ Cancer
- ☐ Asthma
- ☐ Allergies
- ☐ Hepatitis
- ☐ Heart problems
- ☐ Tuberculosis
- ☐ Kidney problems
- ☐ Anxiety / depression

Medications:

Hobbies / activities you enjoy

- ☐ Computer / Internet
- ☐ Video Games
- ☐ Reading
- ☐ Arts & Crafts
- ☐ Sewing
- ☐ Golf
- ☐ Biking
- ☐ Running
- ☐ Water Sports
- ☐ Snow Sports
- ☐ Others:

Do you smoke cigarettes?	YES	NO
Do you drink alcohol?	YES	NO

Do you wear glasses?	YES	NO
Do you wear contacts?	YES	NO

HIPPA : please read and sign

I have read, understood, and acknowledge the Privacy Policy & Practices of Joy Optometry.

I authorize Joy Optometry to use my name on any & all claims that relate to insurance benefits/claims.

I permit a copy of this authorization to be used in place of the original.

x **Date**

x **Date**

x **Date**