WELCOME TO JOY OPTOMETRY

Mr. | Mrs. | Ms. | Dr.
Suffix

First Name

Last Name

MM | DD | YYYY
Birth Date

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
- ☐

text | call | email
Preferred contact method

Phone Number ☐ cell ☐ home

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

Please initial + date + 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.

Date _____ **x** _____