

Welcome To Envision Eyecare – Office of Dr. Christina Fox

Patient Name (full name): _____

If salutation preferred, please select:

Other _____

Date of Birth: _____ **Telephone:** (H) _____

Soc. Sec. #: _____ (W) _____

Mailing Address: _____ (C) * _____

_____ Email * _____

_____ * One or both needed for our appointment system

_____ (i.e. appt reminders, yearly appt recalls, etc.)

Patient Information: Male Female Height: _____ Weight: _____

Race: Other _____

Marital Status:

If married, spouse's full name: _____

If patient is under 18, parent or guardian's name(s): _____

Is patient employed? Yes No Part-time Full-Time

If yes, Employer: _____

Occupation: _____

Is patient a student? Yes No School: _____

How did you hear about us? Other _____

If family, friend, or physician: Name of Referring Person: _____

Has anyone in your household ever been a patient of ours? Yes No

If yes, please give name of patient(s): _____

Have you ever worn glasses? Yes No **Contact Lenses?** Yes No

Do you presently wear glasses? Yes No **Contact Lenses?** Yes No

Have you ever had **any type of eye surgery or eye disease?** Yes No

If yes, which: Other _____

Please list treating doctor and date(s): _____

PAYMENT IS REQUIRED AT TIME OF SERVICE – Please present all medical insurance cards to front desk.

If you do not have insurance, please select your method of payment:

Please email form to: drfox@envisioneyecareohio.com