Welcome To Envision Eyecare – Office of Dr. Christina Fox

Patient Name (full name):_____

If salutation preferred, please circle: Mr. Mrs. Ms. Miss Dr. 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: White Hispanic African American Asian Native American Pacific Islander Other_____

Marital Status: Single Married Separated Divorced Widowed

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? Family Friend Yellow Pages Newspaper Radio Physician 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:

Lasik	cataract(s)	macular degeneration	glaucoma
dry eyes/Sjogren's	corneal ulcer	diabetes retinopathy	amblyopia
ocular trauma	detached retina	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 circle your method of payment: Cash Check Bank Card/Credit Card FSA/HSA