A - B - E

# Tell Us About Yourself

PLEASE PRINT

Date: ____/____/____ Birthdate: ____/____/____ (M D Y) Age: ________ M / F

Name: ______________________ (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: ______________________

Spouse/Friend: ______________

## To better understand your vision needs, please answer all questions (or N/A)

What is your motivation for vision correction? ______________________

How long have you been considering vision correction? ______________________

What is your timeframe for vision correction? ______________________

What concerns do you have about having vision correction? ______________________

Do you wear: ☐ Glasses? ☐ Contact Lenses? ☐ Readers/Bifocals? ________ # of years

Do your glasses/contacts interfere with recreational activities? Yes No

How? ______________________

**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: ______________

## For Office Use Only

| Vision (aided) | DVaccOD: 20 / | DVaccOS: 20 / | P_PACH < |
|---|---|---|---|
| Vision (unaided) | DVascOD: 20 / | DVascOS: 20 / | HWTW < |

Notes: ______________________