THE CONTACT LENS INSTITUTE
AN OPTOMETRIC CORPORATION

Patient Acquaintance Form

Date_____

Name_____

Address_____

City_____ State_____ Zip Code _____

Phone: Home_____Cell _____ Work _____

E-mail_____

Birthdate _____

Occupation or Grade_____

Employer or School _____

Please check one: Single Married Divorced Separated Widowed

Spouses Name or Responsible Party if Minor:

Name_____

Address_____

City_____ State_____ Zip Code _____

Phone: Home_____Cell _____ Work _____

Please circle all that apply:

How did you hear about us?

Insurance Website Social Media Yelp Search engine Signage Mailing/Brochure

Referred by _____

Do you wear vision correction? Glasses (Single vision Progressive Bifocal Other)

Do you wear contact lenses? Soft Hard (RGP) Ortho-K/CRT Scleral Hybrid

Any past eye surgeries? LASIK/PRK/ICL IOL (cataract surgery) Other _____

Any eye conditions (ex: glaucoma, dry eye)_____

Any health conditions _____

Any current medications _____

Any allergies to medications_____

Any family members with eye diseases and condition _____

Last eye exam and Dr. name_____

Last physical exam and Dr. name_____

Please circle: Alcohol – Yes/Social/No Smoking – Yes/No/Former Illicit Drugs – Yes / No