

Welcome Back to Our Office



**YOUNGWOOD
EYE CARE**

Dr. Michel L. Pawlosky, O.D.

Today's Date _____

Please Indicate Any Changes in Personal or Insurance Information:

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

How do you prefer to be contacted?

(Indicate #1 and #2 Choice):

Home # ___ Work # ___ Cell # ___ Text ___ Email ___

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Date of Birth _____ Age _____

Sex M F

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

The mission statement of Youngwood Eye Care is to be the first choice of eye care for our patients. We strive to provide the most comprehensive eye examinations and services while using the highest level of technology and quality eye care products. We ensure a personal experience with the upmost professionalism and guarantee satisfaction.

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

Yes No

How will you settle your account today?

Cash Check Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sun wear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |