Eyecare Professionals, Inc.
Dr. Delton L. Fast Dr. Jeremy M. Fast

WELCOME TO OUR OFFICE

HIPPA information received

Initials _____ Date _____

Today's Date _____

PATIENT INFORMATION

Last Name_____First Name _____MI_____ Nickname_____

Date of Birth _____ Social Security #_____ Sex ☐ M ☐ F

Home Address _____

City _____ State _____ Zip_____

Telephone: Home _____ Cell_____ Business _____

Communication Preference: ☐ phone call ☐ text or ☐ e-mail_____

Employed by _____ Position _____

Business Address _____ Phone _____

Date of Last Visual Examination _____ By whom? _____

Which members of your family are patients of ours? _____

Have you been a previous patient? _____

Physician or Pediatrician _____ Phone _____

Allergies _____

Do you wear or have you worn contact lenses? _____

Has vision training therapy ever been prescribed for you? ☐ yes ☐ no

By Whom? _____

Have you had cataract surgery? ☐ yes ☐ no

If yes, date of surgery: R. Eye _____ L. eye _____

Who performed the surgery? _____

Do you or any members of your family have glaucoma, cataracts, or any eye diseases? ☐ yes ☐ no

Whom? _____

The reason for my visit today is: _____

_____

RESPONSIBLE PARTY ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Last Name_____First Name _____MI_____ Nickname_____

Date of Birth _____ Social Security #____ - _____ - _____ Phone _____

Home Address _____ City_____ State_____ Zip _____

Employed by _____ Phone _____

EMERGENCY CONTACT PERSON (other than someone at same address)

Name_____ Relationship _____

Home _____ Cell Phone_____ Work Phone _____

I wish reports of my visual evaluation be sent to any concerned professional as deemed necessary by the doctor.

Signature_____

ALL PROFESSIONAL SERVICES PAYABLE BY ONE OF THE FOLLOWING:

____ Cash ____ Check ____ Credit/Debit