Date: ____________________

JUST 4 EYES

Offices of Dr. James Bierly

Welcome to our office! We are glad that you have chosen us to care for your vision. Please complete this form and return it to our receptionist when you visit us.

Patient Information

(Please Print)

○ Mr. ○ Mrs. ○ Ms. Name: ____

Frist Middle Initial Last

Date of Birth: ______ / ______ / ________ Age: __________ Social Security #: _________________________________

Contact Information

Street Address: ____

City: _____________________________________ State: ___________________ Zip Code: _______________________

Home Phone #: ____________________ Cell Phone #: ______________________ Work Phone #: __________________

Best Time to reach you? ○ Mornings ○ Mid-Day ○ Afternoon ○ Evenings ○ Other Times: ____________________

Email address: ____

Health History

Family Physician: ___________________________________ Referred By: ______________________________________

Have you ever visited our office before? ○ Yes ○ No If yes, for what the reason for the visit:______________________

_ ____

Date of Last Eye Exam: ______________ With Dr. _________________________ Age of Present Glasses? ____________

Are you currently wearing Contact Lens? ○ Yes ○ No Have you worn Contact Lenses in the past? ○ Yes ○ No

How old are your contacts? ____

Please list any special vision needs (i.e. sports, sewing, piano, work, computer, safety glasses, etc.):

_ ____

Has anyone in your family been treated or diagnosed for any of the following conditions? If yes, please list relationship.

○ Diabetes ○ Heart Disease ○ Blindness

○ High Blood Pressure ○ Glaucoma ○ Color Blindness

○ Thyroid Problems ○ Cataracts

(Health History Continue)

Have YOU been treated for diagnosed for any of the following conditions?

O Diabetes	O Heart Disease	O Blindness
O High Blood Pressure	O Glaucoma	O Color Blindness
O Thyroid Problems	O Cataracts	O Allergies

Do you have any current health problems? O Yes O No If yes, please explain: ______________________________________

_ ____

Please list any medication you are currently taking: O None

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Are you allergic to any medications? O Yes O No If yes, please list all: ____

_ ____

Have you ever had any of the following: O Eye Infection O Eye Injury O Eye Surgery O Other Eye Conditions

If yes, please explain: ____

Please check if you have any of the following:

O Frequent Headaches	O Dizziness	O Eye Pain
O Double Vision	O Light Flashes	O Itching

CONTACT LENS PATIENTS PLEASE CONTINUE:

How many hours per day do you wear your contacts? ____

What type of lenses?

O Hard	O Disposable	O Toric (Astigmatism)
O Gas Permeable	O Daily Wear Soft	
O Bifocal	O Extended Wear Soft	

Type of cleaning solutions you are now using:

O OPTI-FREE O RENU O AO-SEPT O Other: ____

Emergency Contact

Frist Name: ____ Last Name: ____________________________________

Phone #: ____ Relationship: __________________________________

Patient Signature: ____ **Date:** ____________________