WELCOME TO OUR OFFICE

Thank you for choosing ***Drs. Mark and Suzanne Boas*** for your eye care.

Date:_____ Updated: _____ ;_____; _____; _____

Name:_____ Phone(H):_____(O): _____

Cell phone #: _____

Address:_____ City:_____ State:_____ Zip:_____

Email address (for direct communication only, kept private):_____

Age:_____ Date of Birth:_____ SSN.:_____

Occupation/Employer (***if student, grade and school***):_____

Parents names if patient is a minor:_____

Hobbies/Interests:_____

Do you work at a computer terminal? Yes / No If Yes, how many hrs./day?_____

Date of your last eye exam ***if not performed here***: _____ by Dr. _____

Name of Spouse (if applicable):_____ Is he/she our patient? Y / N

Names of Children (if applicable):_____

Have your family members had eye exams in the past year? Y / N

Would you like to schedule an appointment for a family member? Y / N

If you are a new, first-time patient, whom may we thank for referring you to us?_____

If you were not referred by someone, how did you hear about us? (phonebook, insurance list, etc.):

_____

Are you interested in talking to the doctors about:

Contact lenses? Yes / No Refractive Surgery? Yes / No Childrens vision? Yes / No

Learning related vision disorders? Yes / No Other topic? List:_____