Advanced Family Eyecare, LLC

Welcome back to our office! Please take a moment to update your information.

Name: ____ **Date of Birth:** _____________________

Address: ____

Primary Phone: _________-_________-____________ **(Work / Home / Cell)**

Secondary Phone: _________-_________-____________ **(Work / Home / Cell)**

E-Mail Address: ____

How do you prefer to be contacted? ____

Current Vision Insurance: ____

Current Medical Insurance: ____

Height: _________________ **Weight:** _________________ **Gender:** ____________________

Race: ____ ☐ **Decline to Specify**

Ethnicity: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Decline to Specify**

Preferred Language (If other than English): ____

Current Medications: ____

____

Specific Allergies: ____

____

Do you have any specific questions or concerns to discuss with the doctor today?

____

____

Are you wearing contact lenses today? ☐ **Yes** ☐ **No**

Are you able to have your eyes dilated today as part of your annual eye health checkup?

☐ **Yes** ☐ **No** ☐ **I have questions about the dilation process.**