Welcome to Our Practice!

Dr. Lynn Burford, Optometrist

Name: _____ What would you like to be called? _____

Address: _____ Right Handed / Left Handed

Employer (or school): _____ Occupation (or grade): _____

Preferred Phone Number: _____ H W C (please Circle)

Additional Phone Numbers: _____ H W C

DOB: _____ Email address: _____

Spouse (or Parent's Name) _____ Referred by: _____

Current Medications and Dosage: _____

_____

Allergies: _____

Tobacco Use: None___ Smoker___ Former Smoker___ Alcohol Use: Yes____ No____

Currently Pregnant? Yes____ No____ Currently Nursing? Yes____ No_____

Family Physician: _____ Date of Last Physical Check-Up: _____

Have you ever been diagnosed or treated for any of the following health problems?

Allergies____ Arthritis____ Cancer____ Cholesterol____ Diabetes____ High Blood Pressure_____

Heart Disease____ Neurological____ Sinus____ Thyroid____ Unusual Weight Loss/Gain_____

Please list the relationship of any family member diagnosed or treated for the following:

Blindness _____ Macular Degeneration _____ Corneal Problems _____

Diabetes _____ Glaucoma _____ Heart Disease _____

Cancer _____ Retinal Problems _____ Cataracts _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. If we are not a participating provider for your plan, we ask that you pay us and we will be happy to file a claim for you. Most non-participating plans will reimburse the patient directly.

_____ _____ _____

Signature Name of Guarantor (If not the Patient) Today's Date