Established Patient Information Questionnaire

Name: _____ Date of Birth: _____

Has your address changed? Yes___ No___
New Address :_____

Current Email address: _____

-Would you like to receive texts about upcoming appointments and/or updates about your glasses and contact lens orders? Yes___ No___
If yes, please list your cell phone number: _____

-Any changes with your insurance (medical or vision)? Yes___ No___ If so, please list:
_____
_____
_____
_____

-Have you had a new PCP (primary care physician) since your last exam? Yes___ No___
If so, list their name: _____

-Any changes to your medical history? Surgeries, or new diagnosis since your last annual exam? Yes___ No___ If so, please list:
_____
_____
_____
_____

-Any new medications? Yes___ No___ If so, please list:
_____
_____
_____
_____