Welcome to our Office

Dr. Jason Cook and the staff of Dawson's Vision Center want to help you meet all your eye care needs. We are committed to giving you prompt courteous service and want you to be completely satisfied with your experience here. We welcome your questions and your comments. If you need any help, just ask!

Patient Information: (Please fill out both sides of this form)

Mr._______ Mrs._______ Ms._______ Dr._______ Rev._______ Other/Rank___________

First Name:____________________________ Last Name:____________________________ MI:_______

Home Address:____

City:____________________________ State:______________ Zip Code:_____________

Home Ph:(_______) ___________________ Work Ph:(______)____________________ Ext:________

Cell Ph:(_______)_____________________ Social Security #: _________ -_________-__________

Drivers License Number:____________________________ Driver License. State:_________________

Email Address:_____________________________________ Birth date:______/______/______

Responsible Party (fill out only if information is different from patient)

Mr._______ Mrs._______ Ms._______ Dr._______ Rev._______ Other/Rank_______

First Name:____________________________ Last Name:_________________________ MI:______

City: ______________________________ State: _______________ Zip Code: _____________

Home Ph:( )_________________ Work Ph:( )_________________ Cell Ph:( )_________________

Relationship to Patient:____

SS # :_______-_______-_______ Driver Lic. #:_______________________ Driver Lic. State:________

Insurance Information

Vision Insurance: _____________________________________ Vision ID# / Group#__________________________

Medical Insurance : ___________________________________ Medical ID# / Group#:_______________________

Policy Holders Name:____________________________________ Plan Holder Date of Birth: __________________

Plan Holder relationship to Patient (Select One): □ Spouse □ Child □ Parent □ Self

How will you settle your account today? (Select One) : □ Cash □ Check □ Credit Card □ Care Credit

How did you hear about Dawson's Vision Center & Dr. Jason Cook?

□ Social Media □ TV/Radio/Newspaper □ Previous Patient □ Saw sign/Building □ Special Event □ Other Doctor

If other doctor, please list:____________________□ Family/Friend (name)__________________________ □ Web Page

□ Other (please list) ___________________

Reasons for your visit

What is the reason for your visit today?____

Have you ever been diagnosed with any eye problems/diseases?__________________________

I'm interested in contact lenses. Y / N

About your general health

Pharmacy:______________________________ Address:______________________________

Current medications: Many medications can affect the health of your eyes. Please list the names of your medications.

____

Are you pregnant or nursing? ◻ Yes ◻ No

Are you allergic to any medications? ◻ Yes ◻ No If so, please list what medications your are allergic to.

____

Eye Symptoms / History

◻ Cataracts

◻ Diabetic Eye Disease

◻ Dry Eyes

◻ Amblyopia (lazy Eye)

◻ Glaucoma

◻ Floaters or spots

◻ Flashes of light

◻ Eye surgery

◻ Blurred Distance vision

Lifestyle Questions

Do you work at a computer? ◻ Yes ◻ No If yes, how many hours a week?______

Do you have problems reading small print? ◻ Yes ◻ No

Do you have more than one pair of prescription eyewear? ◻ Yes ◻ No

Are there times when you prefer not to wear glasses? ◻ Yes ◻ No

Are your eyes sensitive to bright light? ◻ Yes ◻ No

Do you have trouble reading signs while driving at night? ◻ Yes ◻ No

If you wear bifocals, do the lines or head tilting bother you? ◻ Yes ◻ No

Do you participate in sports or outdoor hobbies? ◻ Yes ◻ No

Payment Information

Payment and/or Co-payments are due at the time of your visit. If payment cannot be made, please reschedule your appointment to a time when payments can be made. We accept for payment: **Cash, Checks, MC, Visa, Discover and Care Credit.**

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Signature: ______________________________ Date: _______________