Welcome To Optometry at the Shops

Diana Ciobanu, O.D.
& Associates

Thank you for providing the following information:

Date:_____
Name: _____Phone number: _____
Birthdate: _____
Home Address : _____
City: _____ Zip Code: _____
Email: _____
If a child:
Parent/Guardian's Name: _____
Parent/Guardian's Address: _____
Occupation: _____
Employed by: _____
Business Address (optional):_____
Business Phone (optional): _____
Please indicate how you were referred to our office:
Referred by a Patient (Patient Name):

_____
Google_____ Yelp_____ Direct Mail _____ Other:_____
Vision Insurance Provider: _____
Date of last examination: _____
Do you wear glasses? _____When were they prescribed? _____
Do you wear contact lenses? Soft_____ Gas Permeable_____ Hard_____
Are you experiencing any of the following vision problems? _____
Reading_____ Computer_____ Distance Vision_____ Discomfort_____ Redness____
Other Vision Problems:_____
Do you experience headaches or migraines? Frequency?

_____
Have you ever had injuries to your head or eyes? Date of injury?

_____
Do you have high blood pressure?

_____
Allergies? Sinus Troubles? Diabetes?

_____
What medications are you currently taking?

_____
Recreation & Hobbies? _____
Additional information that you feel would be helpful: