



Welcome to Blue Ridge Eye Associates!



Patient Name: (Mr. Mrs. Ms. Miss Dr.) _____ **Date:** _____
Date of Birth: _____ **Age:** _____ **E-mail:** _____
Address: _____
Street City, State, Zip Code
Phone Numbers: Home: _____ Cell: _____ Work: _____
E-Mail Address: _____
Occupation/Employer or School/Grade: _____

Briefly, what is the main reason that you came into the office today?

Do you now or have you ever worn: Glasses Contact lenses
 Are you interested in a contact lens fitting today? Yes No

Recent Appointments

Date of last complete eye examination: _____ **By whom:** _____
Date of last complete physical examination: _____ **By whom:** _____

Patient Symptoms

Do you experience any of the following symptoms? **Circle all that apply**

Blurred vision	Eye redness	Jaw pain	Stuffy nose
Eye pain	Loss of vision	Rash	Shortness of breath
Tearing	Flashes/Floaters	Fever	Headache

Patient/Family History

Have you or anyone in your family ever had any of the following conditions?
Circle S for Self and/or F for Family for all that apply

S F Macular degeneration	S F High blood pressure	S F Stroke
S F Glaucoma	S F Thyroid abnormalities	S F Bleeding disorders
S F Diabetes	S F Arthritis	S F Other

Are you taking any medications? Yes No
 If yes, do you allow Blue Ridge Eye Associates to retrieve prescriptions online? Yes No
 Do you have any medical allergies? Yes No If yes, please list: _____

How did you hear about us? Internet Website Friend/Relative Other _____

Fees are due upon services rendered. Please select your preferred method of payment:
 Cash Check Debit Card Medicare Discover Master Card Visa

For vision insurance plans, we will submit claim forms on your behalf for reimbursement directly to you.

We appreciate the opportunity to serve your visual needs



**BLUE RIDGE EYE
ASSOCIATES**

1790 East Market St. Ste 92, Harrisonburg, VA 22801, Phone: 540-434-3937, FAX: 540-526-0032