GIANNOTTI VISION CARE

Anthony P Giannotti, OD
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Patient Information

In order for us to provide the proper eyecare services to you, we ask that you please answer the following questions and fill in the blanks where indicated. All answers to our questions are for our records only and are considered confidential. Thank you very much for your cooperation.

Patient's Name _____ SS# _____
First Middle Initial Last

Home address _____
Number Street City State Zip

Home Phone _____ Work Phone _____ Date of Birth _____

Occupation _____ Employer _____

Spouse's Name _____ Spouse's Employer _____

Children's names, or if patient is a minor, parents' names _____

Family Doctor _____

Former eye care practitioner _____

Whom may we thank for referring you? _____

Reason for visit: _____

Cell #: email:

Do you... (Check box if your answer is yes)

- ☐ Work at a computer?
- ☐ Think you will benefit from thinner, lighter lenses?
- ☐ Have interest in a "test drive" of the latest contact lens design?
- ☐ Have prescription sunglasses?
- ☐ Prefer not to wear your glasses at times?
- ☐ Have more than one pair of current prescription glasses?
- ☐ Have trouble with glare?
- ☐ Have family members in need of eye care?
- ☐ If you wear bifocals, do the lines or head tilting bother you?
  ☐ Yes ☐ No
- ☐ If you wear contacts lenses, are you satisfied with the vision and comfort?
  ☐ Yes ☐ No