

BEAVERTON VISION WORLD

www.bvweyes.com



IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

PATIENT INFORMATION

Today's Date _____

Last Name _____ First _____ MI _____
Address _____
City _____ State _____ Zip Code _____
Home Phone () _____ Work Phone () _____
Mobile Phone () _____ Other () _____
Gender: Male Female Date of Birth ____/____/____
Marital Status: Single Married Divorced Widowed Separated
Occupation _____ Employer _____
E-mail _____

RESPONSIBLE PARTY (if different from above)

Last Name _____ First _____ MI _____
Relationship to patient _____ Gender: Male Female
Home Phone () _____ Work Phone () _____
In case of an emergency whom can we contact?
_____ Relationship _____
Address _____
Home Phone () _____ Work Phone () _____

BVW WARRANTY/POLICY

1. One-year frame warranty against defects caused by normal usage (most frames).
2. One-year warranty for scratches on scratch coated plastic, polycarbonate and anti-reflected coated lenses.
3. 50% redo charge on any prescription changes by outside doctors within 60 days of the original prescription date.
4. When providing your own frame, it is done at your own risk.
5. We will help you make the best eyewear selection possible. **ALL SALES ARE FINAL.** There are no refunds on completed eyewear. Cancellations are subject to a 10% surcharge.

We appreciate your business and estimate time of delivery at *SEVEN to TEN (7-10)* business days. Rush service available at a slight up charge.

Customer Signature: _____

PAYMENT INFORMATION: Visa MasterCard American Express Discover Cash
SORRY, NO CHECKS ACCEPTED. PAYMENT DUE AT TIME SERVICES ARE RENDERED.

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred Vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type _____

Additional Information _____

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Nervous Yes/No Endocrine Yes/No Ears/Nose/Throat Yes/No

Urinary Yes/No Blood/lymph Yes/No Cardiovascular Yes/No

Muscles/bones Yes/No Respiratory Yes/No Allergic Yes/No

Skin Yes/No Headaches Yes/No High blood Pressure Yes/No

Eyes Yes/No Mental Yes/No

Please explain _____

Diabetes Yes/No Type _____ Insulin Dependent Yes/No

Date of diagnosis _____

Allergies to medications? Yes/No Which? _____

Reactions? _____

Other health Problems _____

Current Medication(s) _____ Check if none

Have you had any operations? Yes/No Kind? _____ When? _____

Name of Primary Care Physician _____

Name of Clinic Located at _____

Phone Number () _____ Date of Last Visit _____

FAMILY HISTORY

High Blood Pressure Yes/No Relation _____ Maternal Paternal

Macular Degeneration Yes/No Relation _____ Maternal Paternal

Diabetes Yes/No Relation _____ Maternal Paternal

Retinal Detachment Yes/No Relation _____ Maternal Paternal

Glaucoma Yes/No Relation _____ Maternal Paternal

Cataracts Yes/No Relation _____ Maternal Paternal