Welcome to Coley and Coley Family Eyecare

Name____

Preferred Name _______________________________________

Date of Last Eye Exam ________________

Reason for today's visit _______________________________________

Please Tell Us about your eyes:

I currently wear glasses: __ Full-time __ Part-time (If part-time, how often/when?)
____

I currently wear contacts: __ Full-time __ Part-time (If part-time, how often/when?)
____

Current brand of contacts: ___________________

Are you currently comfortable in your contacts? Y N

When do you typically switch to a new pair of contacts? __________

If you don't wear contact lenses, would you be interested in wearing them part-time? Y N

Please list all current medications (prescription and over-the-counter) If you prefer, you can provide us with a list.

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Please list all Drug allergies: ______________________________________

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. We can not guarantee the accuracy of benefit information given to us by insurance companies.

____ ____________________

Patient Signature Date