

**Dr. Laura Anne Potvin, P.C.**  
**OPTOMETRISTS**

**REGISTRATION**  
**(Please Print)**

Date \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Last Name First Name Initial

Patient street address \_\_\_\_\_

Mailing address if different \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex \_\_\_ M \_\_\_ F \_\_\_ Single \_\_\_ Married \_\_\_ Child \_\_\_ SS# \_\_\_\_\_

Patient Employed by \_\_\_\_\_

Business Phone \_\_\_\_\_

Do you have medical insurance? Yes \_\_\_ No \_\_\_

Does it cover vision? Yes \_\_\_ No \_\_\_

Who is the owner of the insurance? \_\_\_\_\_

Owner of insurance date of birth? \_\_\_\_\_

Relationship to patient? \_\_\_\_\_

If minor child, who is responsible for this account? \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

if different from patient

City, State, Zip \_\_\_\_\_

Who is the patient's primary care physician \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

How did you hear of our office? \_\_\_\_\_

**SEE OTHER SIDE**

This part of the questionnaire will allow our doctors and staff to better meet your needs. The information you provide is confidential. We understand that you will fill this out to the best of your ability. Thank you for your cooperation, my staff is required to have you fill this out mostly for your benefit but also to meet HIPAA requirements.

What type of work are you doing? \_\_\_\_\_

Do you use a computer?  yes  no

If yes, how many hours per day? \_\_\_\_\_

In what capacity do you use the computer?  work  research  shopping  
 games  other, please specify: \_\_\_\_\_

Would you be interested in a computer vision evaluation?  yes  no

What do you enjoy for activities? \_\_\_\_\_

Do you ride a bicycle or motorcycle?  yes  no

Do you enjoy contact sports or sports that incorporate balls, pucks or other hard projectiles?  yes  no

If yes, which sports? \_\_\_\_\_

Do you wear protective eyewear?  yes  no

Are you interested in contact lens wear?  yes  no

Do you wear sunglasses?  yes  no

Are you currently being treated for any conditions by a medical doctor?  yes  no

If yes, what are they? \_\_\_\_\_

medications taken: \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any over the counter medications?  yes  no

If yes, what are you taking? \_\_\_\_\_

\_\_\_\_\_