## VINCENT R. VICCI Jr., O.D., P.A. D.P.N.A.P.

## **Patient Information**

Town: State: Zip: Telephone: Home: ( )	Address: Town: State: Town: Telephone: Home: ( )	
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Telephone: Home: { }	Telephone: Home: ( )	
Email: Date of Birth: Date of Birth: Bace: Ethnicity: Spouse's Name: Phone #: Mother's Name (If Minor) Email: Father's Name (If Minor) Email: Communication Preference: Home #   Work #   Cell #   Email: Pharmacy Name: Phone/Fax:  PATIENTS OCCUPATION OR/SCHOOL: School Name: Grade: Address: Phone #: Employer Name: Phone #: Address: Phone #:  Reason for today's visit: How you were referred to Dr. Vicci: Did you ever wear glasses? For how long? Do you wear contact lenses? For how long? Type: PRIMARY CARE PHYSICIAN: Can we forward your records to them if requested? OCULAR HISTORY: Does your vision blur for any of the following: Driving Ocyular eyes: Ache Burn Tire Water Do you have headaches? For how long? Frequency Sharp Dull Severe Mild When do they occur (what time of day/how often?) How do you treat these headaches?	Email: Date of Birth:  Race:  Race:  Ethnicity:  Spouse's Name:  Mother's Name (If Minor)  Email: Father's Name (If Minor)  Communication Preference:  Home # Work # Cell # Email: Pharmacy Name:  Phone/Fax:  Phone/Fax:  Phone/Fax:  PATIENTS OCCUPATION OR/SCHOOL: School Name:  Address:  Employer Name:  Address:  Phone #:  Employer Name:  Address:  Reason for today's visit:  How you were referred to Dr. Vicci: Did you ever wear glasses?  Do you wear contact lenses?  For how long?  Do you wear contact lenses?  For how long?  Type PRIMARY CARE PHYSICIAN:  Can we forward your records to them if requested?  OCULAR HISTORY:  Does your vision blur for any of the following: Driving  Chalkboard  Watching Movies  Computer/TV  Close work or read Do your eyes: Ache  Burn  Tire  Wat Do you have headaches?  For how long?  For how long?  Chalkboard  Frequency  Sharp  Dull  Severe  Mild  When do they occur (what time of day/how often?)  How do you treat these headaches?	
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Marital Status:Spouse's Name:Phone #:	Marital Status:Spouse's Name:Phone #  Mother's Name (If Minor)Email:	
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Father's Name (If Minor)	Father's Name (If Minor) Email:	#: <u></u>
Communication Preference:	Communication Preference:     Home #   Work #   Cell #   Email:   Phone/Fax:   Phone/Fax:   Phone/Fax:   Phone/Fax:   Phone/Fax:   Phone #:   Address:   Phone #:   Phone Power war glasses?   Por how long?   Phone Number:   Phone Number:   Phone Number:   Phone Power war glasses?   Por how long?   Chalkboard war glasses?   Phone Power war glasses?   Por how long?   Chalkboard war glasses?   Phone Power war glasses?   Por how long?   Phone Power war glasses?   Power war glasses.   Power war glasses.   Power war glasses.   Power war glasses.   Power war glasses.	
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Employer Name:	Employer Name:	
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Do bright lights bother your eyes?Do you ever see things doubler	Do bright lights bother your eyes?Do you ever see things double?	
Have you had any injuries to your head or face?		
	Have you had any surgery?	