



**DR. RICHARD K. MARKS  
OPTOMETRIST**

**APPOINTMENTS** (316) 788-1535  
**EYEWEAR** (316) 788-2888  
**CONTACTS** (316) 788-1590

*A caring, proven practice*

**WELCOME TO OUR OFFICE**

(PLEASE PRINT)

Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_F \_\_\_M

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

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

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

Work Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Employer (or School) \_\_\_\_\_

Occupation (or Grade) \_\_\_\_\_

**YOUR MEDICAL HISTORY**

Allergies	Yes	Arthritis	Yes
Asthma	Yes	Cancer	Yes
Skin Disorder	Yes	Diabetes	Yes
Eye Disease	Yes	Heart Disease	Yes
Eye Injury	Yes	High Blood Pressure	Yes
Eye Surgery	Yes	Kidney	Yes
Lazy Eye	Yes	Nerves	Yes
Cataracts	Yes	Other _____	Yes
Glaucoma	Yes		
Macular Degeneration	Yes		

**CURRENT MEDICATIONS**  
(Rx or Over the Counter)

Antihistamines	Yes	_____
Diuretics (Water Pills)	Yes	_____
Blood Pressure Medication	Yes	_____
Oral Contraceptives	Yes	_____
Sleeping Medication	Yes	_____
Eye Drops	Yes	_____
Other _____	Yes	_____

Are you currently under the care of a physician? No Yes

If yes, who? \_\_\_\_\_ Why? \_\_\_\_\_

Name of family physician \_\_\_\_\_

**YOUR FAMILY MEDICAL HISTORY**

Blindness	Yes	_____
Cataracts	Yes	_____
Glaucoma	Yes	_____
Diabetes	Yes	_____
Macular Degeneration	Yes	_____
Heart Disease	Yes	_____
Other _____	Yes	_____

When did you have your last eye health evaluation? \_\_\_\_\_

Who was your eye doctor? \_\_\_\_\_

Do you wear contact lenses? Yes No

Are you satisfied in your contact lenses? Yes No

What is the major purpose of this visit \_\_\_\_\_

Any Concerns with your present contact lenses or eye wear? \_\_\_\_\_

Spouse (or Parent's Name) \_\_\_\_\_

Spouse (or Parents Work Phone) \_\_\_\_\_

Vision Insurance \_\_\_\_\_

*We like to say thanks to the patients who refer others to our practice.  
Please help us do so by taking a moment to let us know how you first  
learned about Dr. Marks.*

How did you first hear about our office?

- Friend or Relative - Who? \_\_\_\_\_
- Another Health Care Practitioner? \_\_\_\_\_
- Yellow Pages - Which directory? \_\_\_\_\_
- Newspaper Advertisement? \_\_\_\_\_
- Civic Group or Community Event \_\_\_\_\_
- Other \_\_\_\_\_
- Referred by \_\_\_\_\_

**How will you settle your account today?**

- Check
- Cash
- Credit Card

**SIGNATURE ON FILE FOR INSURANCE PURPOSES**

I agree to pay all fees and finance charges not paid by insurance for myself and family members.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (PRINTED)

\_\_\_\_\_  
Date