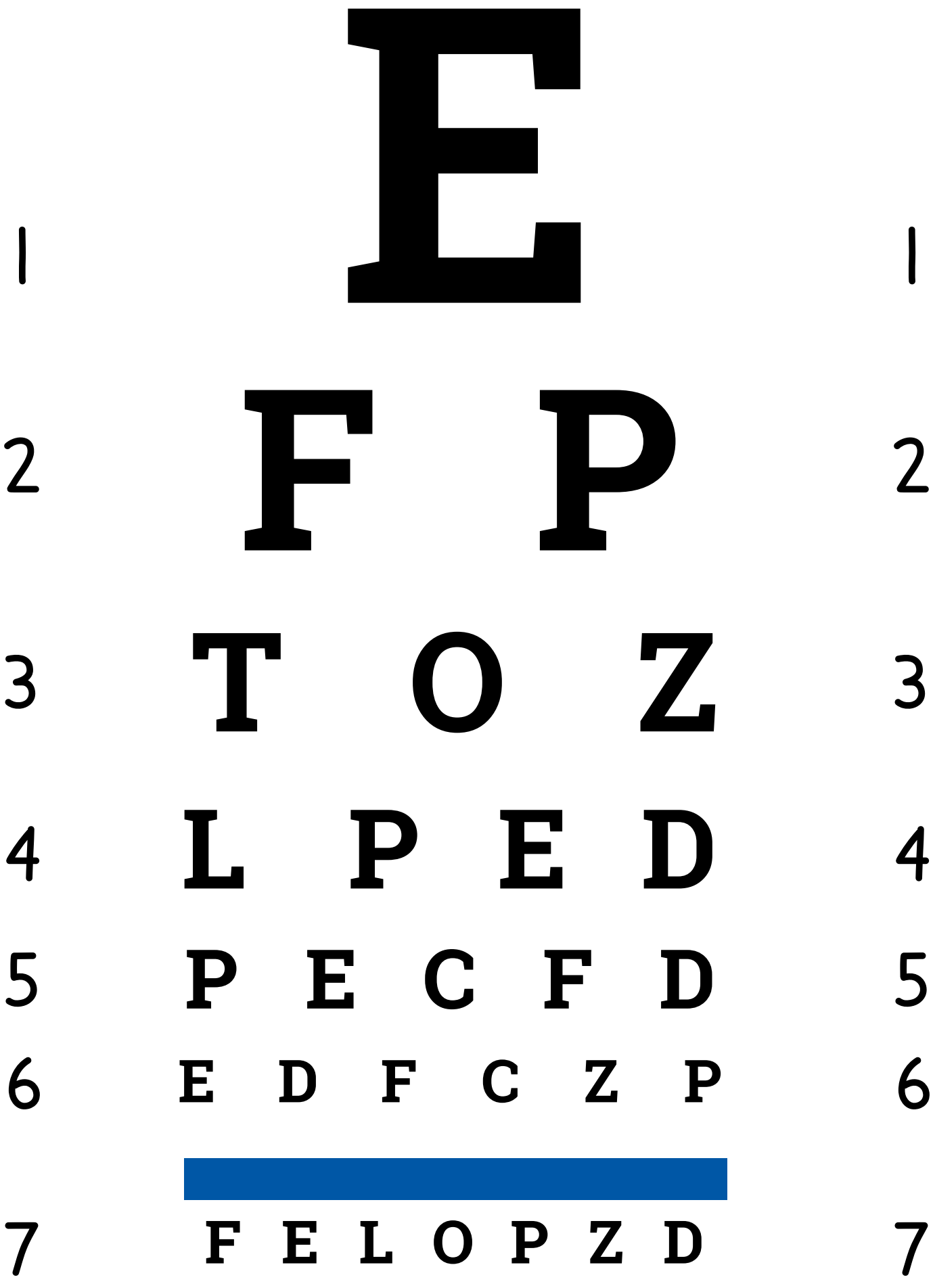

1 E 1
2 F P 2
3 T O Z 3
4 L P E D 4
5 P E C F D 5
6 E D F C Z P 6
7 F E L O P Z D 7

CLINIC HOURS

Monday	8:00 - 5:00
Tuesday	8:00 - 5:00
Wednesday	8:00 - 5:00
Thursday	8:00 - 5:00
Friday	8:00 - 5:00
Saturday	8:00 - 3:00
Sunday	CLOSED

Patient Eye Exam

Patient Name: _____ Age: _____

Patients
Eye Color: ☐ ● ☐ ● ☐ ● ☐ ● ☐ ●

Circle the lines the patirnt can read

1 2 3 4 5 6 7

Does the patiend need glasses: Yes ☐ No ☐

Notes: _____

_____

_____

_____

_____

Optician's: name: _____

Signature: _____

WELCOME
PLEASE SIGN IN

Patients Name	Time	Doctor's Name

PATIENT CHART

Patient's Name:

Age:

Eye color:

Symptoms

- ☐ BLURRY VISION
- ☐ SHORT SIGHTED
- ☐ LONG SIGHTED
- ☐ HEADACHES
- ☐ ITCHY EYES
- ☐ PUFFY EYES
- ☐ RED EYES
- ☐ OTHERS

Treatment

- ☐ EYE DROPS
- ☐ CONTACT LENSES
- ☐ GLASES

Test

- ☐ EYE TEST
- ☐ PRESSURE CHECK

Diagnosis: _____

Optician's Name: _____

Signature: _____

WAITING ROOM

EYE TEST ROOM

HELLO

My Name is:

RECEPTIONIST

HELLO

My Name is:

OPTOMETRIST

HELLO

My Name is:

OPTICIAN

Welcome to The Waiting Room

Please Wait Until Your Name is Called

WELCOME

The Clinic Is

OPEN

SORRY

The Clinic Is

CLOSE

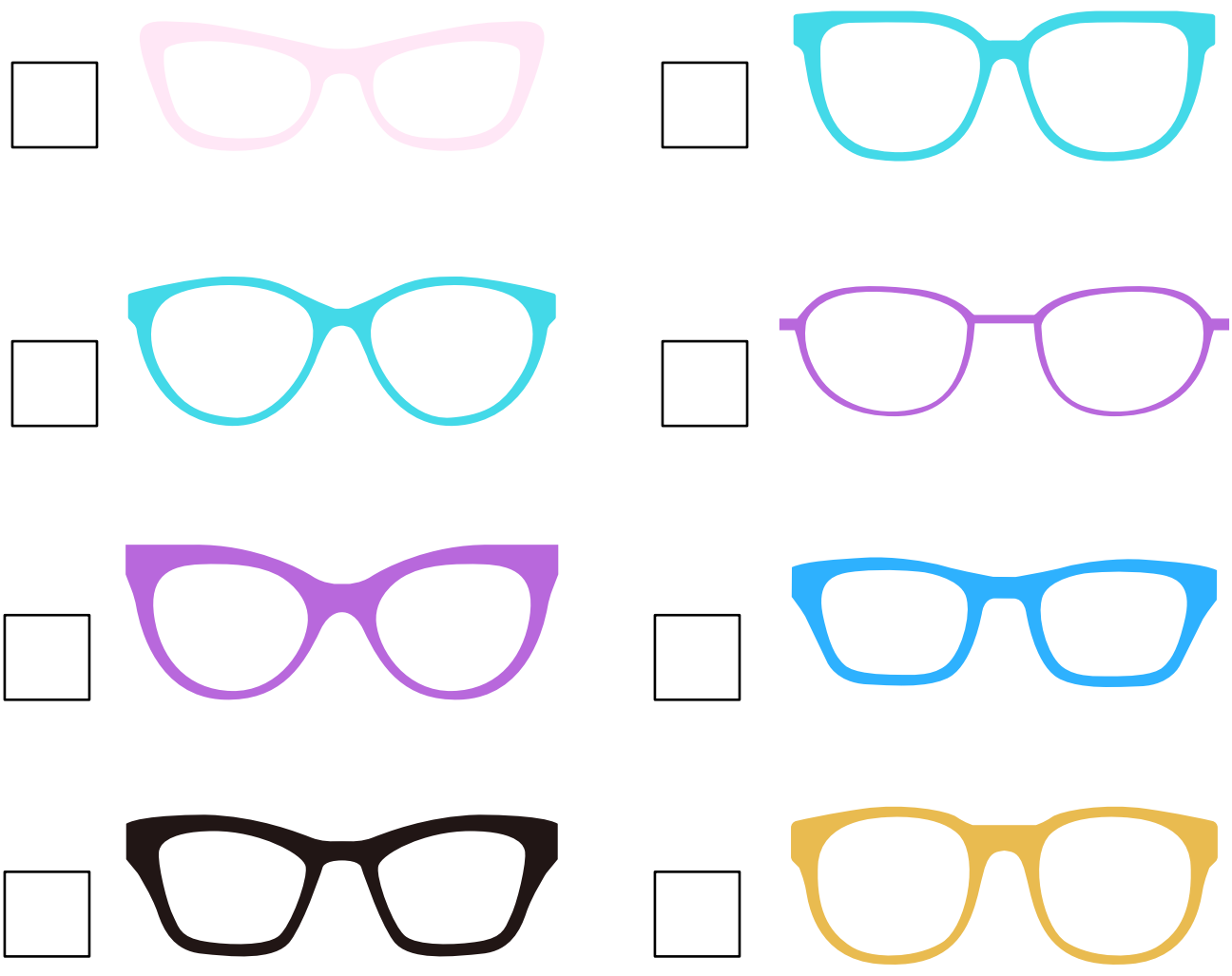
Frame Order Form

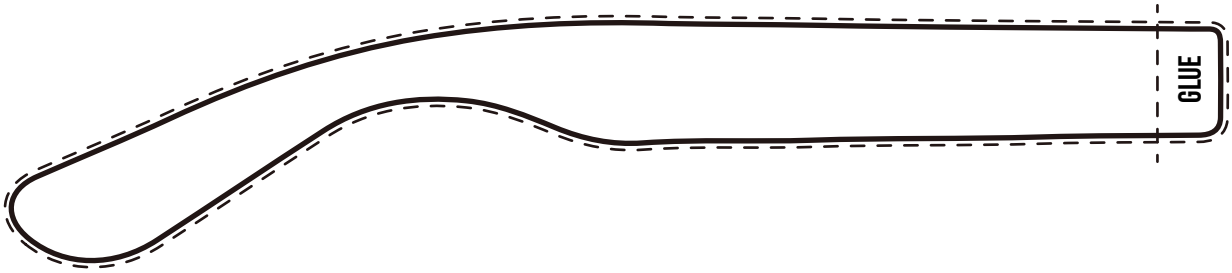
Patient's Name:

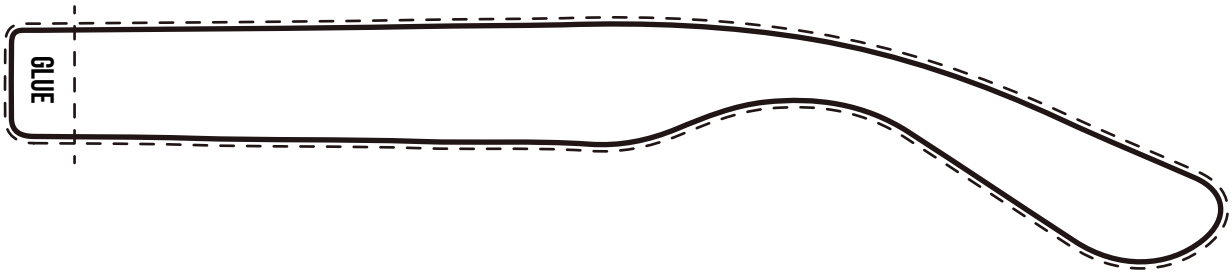
Age:

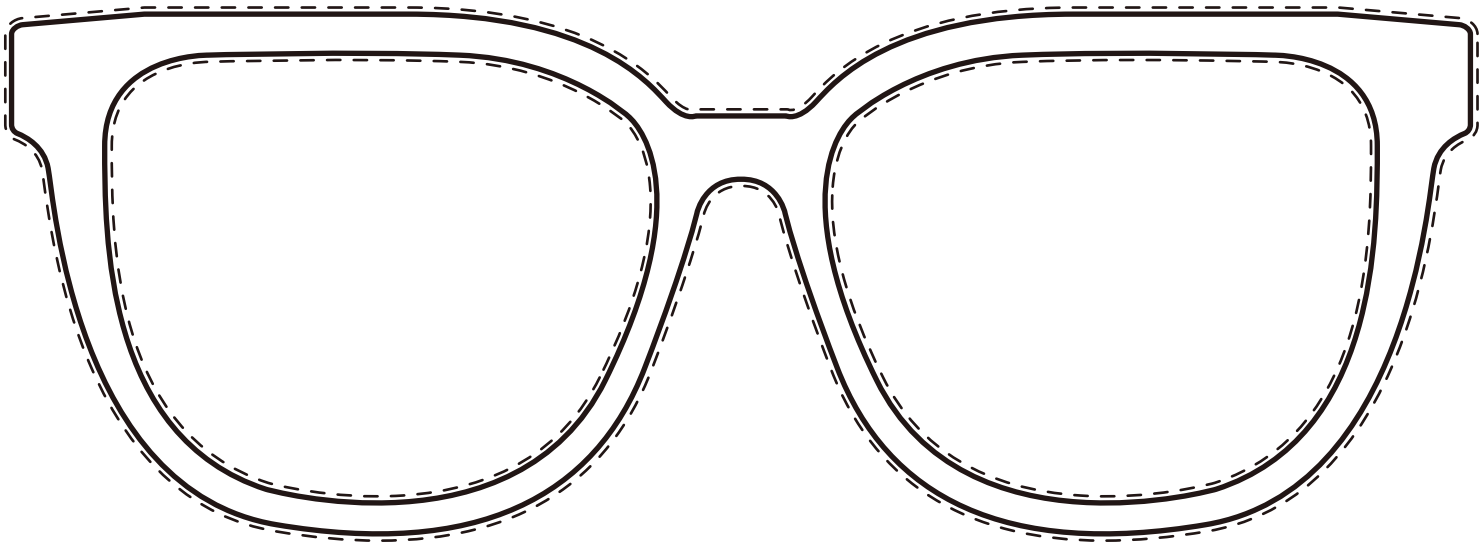
Eyeglasses Options

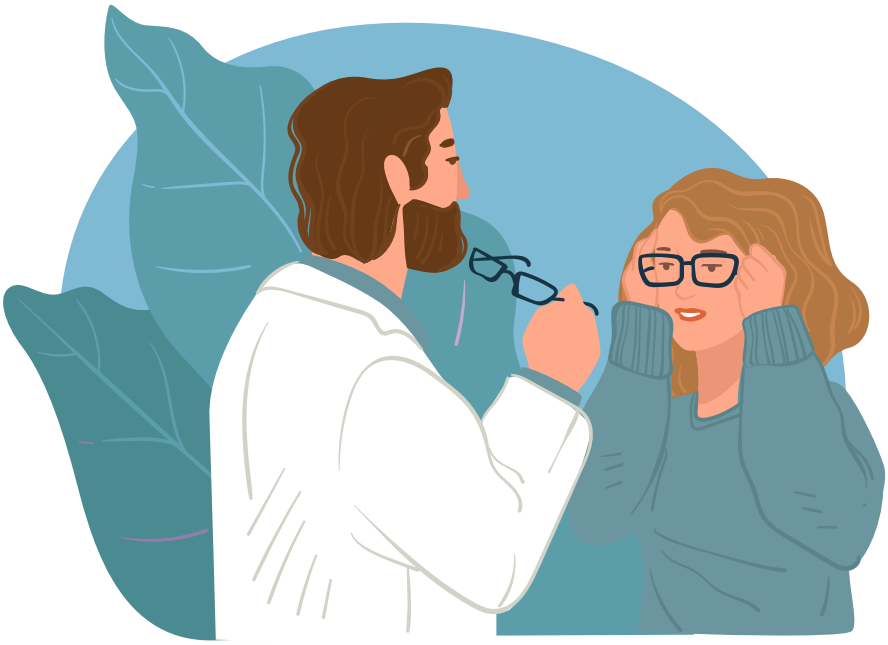
Check yout Selection




GLUE


GLUE





Eye Doctor

Pretend Play