

Name: _____ If child, parent/s name: _____ Today's Date: ____ / ____ / ____

Street, City, State, Zip: _____ Phone: _____

E-mail Address: _____ Cell Phone: _____ Work Phone: _____

Birth Date: ____ / ____ / ____ Soc. Security #: ____ / ____ / ____ In Emergency, Contact Name/Phone: _____

Previous Eye Doctor, City, and State: _____ Last Eye Exam: ____ / ____ / ____

Medical Doctor, City, and State: _____ Last Medical Exam: ____ / ____ / ____

Employer: _____ Occupation: _____ Hours on the Computer per Day: ____

Lifestyle (Hobbies, Sports, etc.) _____

How did you hear about us? (Please circle.) Family, Friend, Phone Book, Insurance Listing, Radio, Newspaper, Dr. Referral/Name

Insurance Information*Please provide your vision plan information. If we are providers, we will submit a claim.*

Insurance Company: _____ Group Name: _____

Member's Name: _____ Date of Birth: ____ / ____ / ____ Soc. Security #: ____ / ____ / ____

I.D. #: _____ Group #: _____ Your relationship to member: _____

Vision NotesDo you wear glasses? no yes; Single Vision Progressive Bifocal Trifocal If yes, how old is your present pair of lenses? _____Do you wear contact lenses? no yes Single Vision Monovision Bifocal If yes, how old is your present pair of lenses? _____Type of contact lenses: Rigid Soft: 1 Pair/Year Extended Disposable (Frequency replaced? _____) Are they comfortable? no yes

Current brand of contact lenses: _____ Brand of lens care solution: _____ Are you unable to use any solutions? _____

Have you ever had any of the following (Please circle.): lazy eye, drooping eyelid, prominent eyes, cataracts (removed? no yes), eye injury, eye infections, other eye surgeries or conditions. Explain: _____Do you drive? no yes Do you have visual difficulty when driving? no yes If yes, please explain: _____

Any other visual complaints today? _____

Are you interested in: Contacts (Circle: Full-time, Part-time, Sports) Glasses (Type? _____) Lasik Surgery Corneal Refractive Therapy (CRT)**Medical History**Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List all major injuries surgeries and/or hospitalizations you have had: _____

Are you pregnant, recently delivered and/or nursing? no yes If yes, how long? _____***** **Please turn this form over and complete side two** *****