



NAME: _____ AGE: _____ D.O.B. ____/____/____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEX: M / F EMAIL ADDRESS: _____ REFERRED BY: _____

PHONE NUMBERS: (HOME) _____ (WORK) _____ MARITAL STATUS: M S D W

OCCUPATION: _____ COMPANY NAME: _____

WORK ADDRESS: _____

EMERGENCY CONTACT: _____ TELEPHONE #: _____

INSURANCE CARRIER: _____ SS#: _____

ID/POLICY #: _____ GROUP (if applicable): _____

PRIMARY CARDHOLDER'S NAME: _____ D.O.B.(if applicable): ____/____/____

MEDICAL HISTORY: PLEASE CHECK IF YOU HAVE THE FOLLOWING

___ HIGH BLOOD PRESSURE ___ DIABETES ___ THYROID DISEASE ___ EYE DISEASE

ARE YOU PREGNANT? ___ YES ___ NO ARE YOU NURSING? ___ YES ___ NO

HAVE YOU EVER HAD EYE SURGERY OF ANY KIND? ___ YES ___ NO

IF YES, WHAT TYPE OF SURGERY? _____

DO YOU HAVE ANY DRUG ALLERGIES? ___ YES ___ NO IF YES, PLEASE LIST: _____

DO YOU TAKE MEDICATION DAILY? PLEASE LIST (INCLUDE EYE MEDICATIONS): _____

DO YOU HAVE A FAMILY HISTORY OF ANY EYE DISEASE SUCH AS GLAUCOMA?

PLEASE LIST: _____

DO YOU WEAR GLASSES?: ___ YES ___ NO CONTACTS? ___ YES ___ NO

ARE YOUR CONTACTS (circle one)?: SOFT HARD GAS PERMEABLE DON'T KNOW

HOW LONG HAVE YOUR CONTACTS BEEN OUT OF YOUR EYES?: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT WE MAY HONOR YOUR PRIVACY:

May we leave a message on your answering machine at home? ___ YES ___ NO

May we leave a message at your place of employment? ___ YES ___ NO

May we discuss your medical condition with a family member? ___ YES* ___ NO

*If yes, name of family member: _____ Relationship: _____

SIGNATURE: _____ DATE: _____