MANDEL VISION®

NAME: _____AGE: _____ D.O.B._____/_____/_____ SEX: M / F

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

EMAIL: _____ REFERRED BY: _____ MARITAL STATUS: M S D W

PHONE NUMBERS: (HOME) _____ (WORK) _ _____ (CELL) _____

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

FEMALE PATIENTS: 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 OR KERATOCONUS?

PLEASE LIST: _____

DO YOU WEAR GLASSES?: _____YES _____NO CONTACTS? _____YES _____NO

TYPE OF CONTACTS: (circle one): SOFT SOFT-TORIC RIGID GAS PERMEABLE (RGP) HARD

WHEN DID YOU LAST WEAR YOUR CONTACT LENSES? _____

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: _____