PERSONAL INFORMATION

LAST NAME FIRST NAME MI

ADDRESS CITY STATE ZIP

BIRTHDAY PREFERRED NAME

INSURANCE INFORMATION

VISION INSURANCE INSURED'S NAME

INSURED'S SSN INSURED'S DOB INSURED'S EMPLOYER

MEDICAL INSURANCE INSURED'S NAME

INSURED'S SSN INSURED'S DOB INSURED'S EMPLOYER

HEALTH HISTORY

Who is your physician? When was your last physical?

☐ DIABETES	☐ RESPIRATORY PROBLEMS	☐ CANCER
☐ HIGH BLOOD PRESSURE	☐ STROKE/NEUROLOGICAL	☐ KIDNEY PROBLEMS
☐ HIGH CHOLESTEROL	☐ CARDIOVASCULAR PROBLEMS	☐ SKIN DISORDERS
☐ THYROID PROBLEM	☐ BLOOD CLOTTING/ANEMIA	☐ HIV/AIDS
☐ DEPRESSION	☐ SICKLE CELL/ANEMIA	☐ ARTHRITIS
☐ HEPATITIS	☐ TUBERCULOSIS	☐ Are you pregnant?
☐ OTHER (please explain)		How many months?

Date of last eye exam Name of eye doctor

Have you ever been treated for or diagnosed with the following?

☐ CATARACTS	☐ GLAUCOMA	☐ EYE INFECTION
☐ LAZY EYE	☐ MACULAR DEGENERATION	☐ EYE SURGERY
☐ CROSSED EYE	☐ RETINAL TEAR/DETACHMENT	☐ EYE TRAUMA

What are your current symptoms?

Do you have a family history of the following?

☐ DIABETES	☐ GLAUCOMA	☐ LAZY EYE
☐ HIGH BLOOD PRESSURE	☐ RETINAL TEAR/DETACHMENT	☐ CROSSED EYE
☐ BLINDNESS	☐ MACULAR DEGENERATION	☐ CATARACTS

What do you like about your current glasses or contacts?

What do you dislike about your current glasses?

CONTACT INFORMATION

Home phone:

Work Phone:

Cell Phone:

Email:*

Which is best to reach you?

☐ Home

☐ Work

☐ Cell

☐ Email

*Please enter your email address if you would like to receive email on new products and services You can unsubscribe at anytime. The mailing list is private and will not be sold.

LIST MEDICATIONS

ALLERGIES