Patient's name:____

Address:____

City, State:___________________________________Zip:___________

Home Phone:__________________Work Phone:___________________

E-mail Address:_______________________________Sex: M F

Occupation:___________________Date of Birth:__________________

Referred By:___________________SS #__________________________

Age of Present Glasses:_______________Last Eye Exam:____________

Medical Coverage / Health Insurance (HIP, United, BCBS, etc.):____________________

	Yes	No
Have you been to this office before?		
Do you have HIP Insurance?		
Do you have a Vision Plan (VSP, Davis, Union, etc.)		
Do you have Medicare coverage?		
Do you have Medicaid coverage?		
Do you have High blood pressure?		
Do you have Heart Problems?		
Do you have Diabetes?		
Allergies to any medications?		
Do you have Glaucoma? Family History of Glaucoma?		
Do you have cataracts or cataract sugery?		
Name of Dr. who performed surgery		
Date of surgery		
Do you suffer from headaches?		
Does sunlight or bright lights bother you?		
Do you have trouble with night driving?		
Do you Frequently use a computer?		
Have you ever had eye surgery? Date?		
Are you Interested in wearing contacts?		
Do you now wear contacts? Type & Rx?		
Are you interested in a free LASIK surgery consult?		
May we contact you via phone, e-mail, fax, mail regarding your glasses and appointments?		

PAYMENT EXPECTED AT TIME OF VISIT