

Name Last _____ First _____ M.I. _____

Address _____ City _____ ST _____ Zip _____

Birthday _____ Sex: M F S.S.# _____ Driver's License # _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address: _____

Employer _____ Occupation _____

Spouse Name or Parents if minor _____

Emergency Contact Name: _____ **Phone:** _____

INSURANCE INFORMATION

Vision Insurance _____ Medical Insurance _____

Insured's Name _____ Relationship to patient _____

Birthday _____ S.S. # _____

Employer _____

Is a Referral required from you PCP? **YES** **NO**

Primary Care Physician _____ PCP Phone _____

Last Eye Exam _____ Doctor _____

Do you wear glasses? Yes _____ No _____

Do you wear contact lenses? Yes _____ No _____

Are you interested in contact lenses? Yes _____ No _____

Do you use a computer? Yes _____ No _____

Are you allergic to any medication? Yes _____ No _____

If yes, please list below

Medications you are currently taking

To Treat Condition
