Welcome! Completing this form helps provide you with the best eye care possible. Thank you!

Name_____**Preferred name**_____

Mailing Address_____**City/State**_____**Zip code**_____

Date of Birth___/___/_____**Age**_____**Social Security #**____-___-____**Primary Phone#**_____

Occupation (or grade in school)_____**Alternate Phone #**_____

Employer (or school attended)_____**Gender** □M □F **Weight**_____**Height**_____

Email Address_____ **Preferred Communication** □Email □Postal □Telephone

Preferred Language □English □Spanish □Other □Decline **Martial Status** □Single □Married □Divorced □Widowed

Race □White □American Indian □Asian □African American/ Black □Hispanic □Native Hawaiian/ Pacific Island □Decline

Ethnicity □Hispanic/ Latino □Non-Hispanic/ Latino □Decline to answer

Vision Insurance _____**Member ID#**_____

Medical / Health Insurance _____**Member ID #**_____

Primary Care Provider_____**Location**_____**Phone**_____

Referred by □Primary Care Provider □Patient _____ □Other _____

I currently Wear □Glasses □OTC Readers □Soft Contact Lenses □RGP Contact Lenses □Toric □ Multi-focal

Reason for exam today?_____

Allergies □Seasonal □Sinus Problems □Latex □Drug_____

List of Medications Currently Being Taken_____

_____

Personal History □Diabetes □High Blood Pressure □Thyroid □Heart □COPD □Cholesterol □Cancer □Smoker
□Light Sensitive □Irritated Eyes □Glare Problems □Frequent Headaches □Double Vision □Lazy Eye □Eye Surgery
□Color Vision Defect □Head or Eye Injury □Glaucoma □Cataracts □Macula Degeneration □Other_____

Family History □Diabetes □High Blood Pressure □Thyroid □Heart □COPD □Cholesterol □Cancer □Smoker
□Light Sensitive □Irritated Eyes □Glare Problems □Frequent Headaches □Double Vision □Lazy Eye □Eye Surgery
□Color Vision Defect □Head or Eye Injury □Glaucoma □Cataracts □Macula Degeneration □Other_____

Payment for professional vision services is due at the completion of the visit. Glasses and contact lenses require a 50% deposit before ordering. Complete payment is due when any materials are received. The patient or responsible party will pay for services rendered which are not fully covered by an insurance or third party plan. If an account becomes delinquent, the patient will pay the balance plus reasonable collection agency fees and interest on the unpaid account. I give my permission for this office to exchange patient chart information with insurance or third party carriers and consulting doctors or professional involved in my care. My consent is good for a all future services.

Today's Payment will be made by □Cash □Check □Credit Card □Flexible Spending Account □Care Credit

I have read and understand the above paragraph

Signature_____**Date**_____