

Last Name		First	Nickname	(Circle one) Mr. Mrs. Dr. Ms. Miss	Home Phone
Home (Street) Address				Work Phone	
City & State		Zip Code	Name of Spouse		Spouse's Work Phone
Date of Birth	Age	Social Security Number		Driver's License Number	
Whom May We Contact In Case of Emergency?				Phone	
Your Occupation (Indicate if Student)		Employed by		Street Address, City, State, Zip Code	
Who is responsible for your payment?		Payment Choice Today: Cash Check Credit Card ATM		Insurance Company: VSP MESC Medicare Other:	
Name(s) of Children:					

Whom May We Thank for Kindly Referring You to Us? _____

Please check any of the following which apply to you:

- Blur, strain, discomfort at far
- Blur, strain, discomfort at near
- Tired or sleepy from reading
- Frequent headaches
- Sensitive to bright lights
- Have taken eye exercises
- Have worn contact lenses

- Double vision
- Eye disease
- Eye surgery
- Eye ulcer
- Skull fracture or concussion
- Crossed or turned eye

Circle if Self or Family:

- Blindness S F
- Glaucoma S F
- Cataracts S F
- Diabetes S F
- High Blood Pressure S F
- Arthritis S F

Present lenses are worn constantly near only far only How old? _____

What medication(s) are you taking? _____

For what problem? _____

Do you have allergies? No Yes, to _____ Do you have hayfever? No Yes

Please check those VISUAL TASKS that you do often:

- Deskwork
- Computer Work
- Bookkeeping / Accounting
- Artwork / Crafts
- Typing
- Sewing / Needlework
- Cooking

- Prolonged reading
- Golfing
- Driving / Biking
- Fishing
- Jogging / Walking
- Swimming / Beachgoing
- Skiing

- T.V.
- Movies
- Theatre
- Dining Out
- Dancing
- Cards
- Shopping

Other VISUAL TASKS not listed _____

Successful contact lens patients comprise a large part of our practice. As a courtesy to you, we offer a no-charge try-on demonstration of SOFT LENSES. Why FREE? To make it easy for you to find out, without obligation, how comfortable and easy contact lenses have become. Many are very pleasantly surprised.

Yes, I'm definitely interested Maybe, tell me more No, not at this time

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides and have completed the above form. I certify that this information is true and correct to be the best of my knowledge. I will notify you of any changes in my health status as well as any of the above information.

Your signature (or parent, if a minor) _____ Date _____