

WELCOME BACK TO OUR OFFICE

PLEASE MAKE ANY CHANGES TO YOUR PERSONAL INFORMATION

NAME _____ - TODAY'S DATE _____
 ADDRESS _____ YOUR E-MAIL ADDRESS _____
 CITY _____ - VISION INSURANCE COMPANY / ID # _____
 STATE _____ ZIP _____
 HOME PHONE _____ MEDICAL INSURANCE COMPANY / ID # _____
 EMPLOYER _____
 OCCUPATION _____ SSN _____
 WORK PHONE _____

PERSONAL & FAMILY MEDICAL HISTORY

CURRENT MEDICATIONS (RX AND OTC)

	SELF	FAMILY		SELF	FAMILY		
ALLERGIES	___	___	GLAUCOMA	___	___	ANTIHISTAMINES	Y N _____
ASTHMA	___	___	EYE DISEASE	___	___	BLOOD PRESSURE	Y N _____
ARTHRITIS	___	___	HEART DISEASE	___	___	ORAL CONTRACEPTIVES	Y N _____
CANCER	___	___	EYE INJURY	___	___	EYE DROPS	Y N _____
DIABETES	___	___	EYE SURGERY	___	___	OTHER MEDICATIONS	_____
			HIGH BLOOD PRESSURE	___	___	ALLERGIES TO MEDICATIONS?	Y N _____

PHYSICIAN'S NAME _____ CLINIC NAME _____

ARE YOU SATISFIED WITH YOUR CURRENT GLASSES Y N

DO YOU HAVE MORE THAN 1 PAIR OF CURRENT Rx GLASSES Y N

DO YOU WEAR CONTACT LENSES Y N

ARE YOU SATISFIED WITH YOUR CURRENT CONTACT LENSES Y N

ARE YOU INTERESTED IN A 'TEST DRIVE' OF THE LATEST IN CONTACT LENS DESIGN Y N

DO YOU EXPERIENCE?

ANY DISCOMFORT WITH YOUR EYES Y N

PROBLEMS WITH GLARE OR REFLECTION Y N

SENSITIVITY TO LIGHT Y N

FLOATERS OR FLASHES OF LIGHT Y N

I UNDERSTAND THAT ALL CHARGES ARE MY RESPONSIBILITY TO PAY. IF I CARRY INSURANCE, I REALIZE THAT INSURANCE PAYMENTS DO NOT ALWAYS COMPLETELY COVER ALL FEES AND THAT I AM RESPONSIBLE FOR THE AMOUNT NOT COVERED.

SIGNATURE _____ DATE _____