NAME ______________________________ PHONE ____________________

ADDRESS ______________________________ MOBILE [__] HOME [__]

______________________________ TEXTING OK Y or N

EMAIL ADDRESS ______________________________ OCCUPATION ____________________

SEX [ ] M [ ] F AGE _____ BIRTHDATE ______________ [ ] SINGLE [ ] MARRIED [ ] WIDOWED

IF UNDER 18 NAME OF PARENT/GUARDIAN: ______________________________

VISION PLAN

NAME OF INSURANCE ______________________________ ID NUMBER ____________________

SUBSCRIBER'S NAME ______________________________ RELATIONSHIP TO SUBSCRIBER ____________

SUBSCRIBER'S DATE OF BIRTH ____________________

HEALTH INSURANCE

NAME OF INSURANCE ______________________________ ID NUMBER ____________________

SUBSCRIBER'S NAME ______________________________ RELATIONSHIP TO SUBSCRIBER ____________

SUBSCRIBER'S DATE OF BIRTH ____________________

PRIMARY CARE PHYSICIANS NAME: ______________________________

HOW DID YOU HEAR ABOUT US? ______________________________

WHAT ACTIVITIES DO YOU SPEND A LOT OF TIME DOING?

[ ] DRIVING [ ] READING [ ] TV ***COMPUTER USE*** ________ ***HOURS PER DAY***

[ ] CONTACT SPORTS [ ] HUNT [ ] FISH [ ] GARDEN [ ] OTHER ______________

DO YOU WEAR GLASSES? .... [ ] ALL DAY [ ] ON AND OFF [ ] NO

ARE YOU INTERESTED IN WEARING CONTACT LENSES? .... [ ] YES [ ] NO

CONTACT LENSES [ ] _______ HRS PER DAY ________ DAYS PER WK ______________ TYPE OF CONTACT LENS SOLUTION

DO YOU SLEEP WITH YOUR CONTACTS [ ] Y [ ] N ________ DAYS PER WEEK ________ DAYS PER MONTH

REPLACEMENT SCHEDULE: [ ] DAILY [ ] WEEKLY [ ] BI-WEEKLY [ ] MONTHLY [ ] OTHER ________

MEDICAL HISTORY: PLEASE CHECK CONDITIONS YOU HAVE OR HAD IN THE PAST:

[ ] DIABETES
[ ] HEART CONDITION
[ ] HIGH BLOOD PRESSURE
[ ] STROKE
[ ] CANCER TYPE ____________
[ ] MACULAR DEGENERATION
[ ] CATARACTS
[ ] GLAUCOMA
[ ] RETINAL DISEASE
[ ] POOR COLOR VISION
[ ] LAZY EYE
[ ] HIGH CHOLESTEROL
[ ] HEADACHES

[ ] ASTHMA
[ ] HEPATITIS
[ ] HIV VIRUS
[ ] PREGNANT NOW
[ ] THYROID CONDITION
[ ] PREMATURE BIRTH
[ ] DOUBLE VISION
[ ] EYE INFECTION
[ ] EYE INJURY
[ ] DRY EYE
[ ] EYES WATER
[ ] OTHER ____________
[ ] ARTHRITIS

[ ] SEEING HALOS
[ ] FLOATERS
[ ] FLASHES
[ ] SENSITIVITY TO LIGHT
[ ] BLURRED VISION
{ } DISTANCE W/GLASSES { } DISTANCE W/OUT GLASSES
{ } NEAR W/GLASSES { } NEAR W/OUT GLASSES
[ ] ALLERGIES
SPRING FALL ALL YEAR
[ ] I SMOKE _______ PACKS PER DAY
[ ] CONSUME ALCOHOL ________ DRINKS PER WEEK
[ ] EYE SURGERY ______________

FAMILY HISTORY PLEASE CIRCLE TO INDICATE RELATIONSHIP MOTHER (M) - FATHER (F) - SISTER (S) - BROTHER (B)- MATERNAL/PATERNAL GRANDFATHER (MGF) (PGF) - MATERNAL/PATERNAL GRANDMOTHER (MGM, PGM)

[ ] HEART CONDITION M F S B MGF PGF MGM PGM
[ ] HIGH BLOOD PRESSURE M F S B MGF PGF MGM PGM
[ ] RETINAL DISEASE M F S B MGF PGF MGM PGM
[ ] POOR COLOR VISION M F S B MGF PGF MGM PGM
[ ] HIGH CHOLESTEROL M F S B MGF PGF MGM PGM
[ ] MACULAR DEGENERATION M F S B MGF PGF MGM PGM

[ ]GLAUCOMA M F S B MGF PGF MGM PGM
[ ]CANCER M F S B MGF PGF MGM PGM
[ ]DIABETES M F S B MGF PGF MGM PGM
[ ]STROKE M F S B MGF PGF MGM PGM
[ ]CATARACTS M F S B MGF PGF MGM PGM
[ ] LAZY EYE M F S B MGF PGF MGM PGM

LIST ALLERGIES YOU HAVE TO **MEDICATIONS AND REACTION** ______________________________

LIST THE **MEDICATIONS/VITAMINS/HERBS** YOU ARE PRESENTLY TAKING ______________________________

PLEASE GIVE YOUR VISION INSURANCE PLAN AND HEALTH INSURANCE CARD TO THE FRONT DESK STAFF WITH THIS FORM -- THANK YOU **DATE** ______________________________