



PLEASE PRINT INFORMATION:

Name _____ Date of Birth _____
(Last) (First) (MI)

Address _____
(Street) (City) (Zip Code)

Home Phone _____ Work Phone _____ Social Security No. _____

Employer _____ Occupation _____

Name of Spouse, Parent or Guardian _____

Referred By _____ Primary Care Physician _____

Have you ever had eye surgery? If yes, please explain _____

Have you ever had an eye injury? If yes, please explain _____

Do you have any of the following: Blindness Cataract Eye muscle problems
 Glaucoma Macular Degeneration Retinal Problems

Do you wear glasses or contact lenses? If yes, for how long? _____

Date of last eye examination: _____

INSURANCE INFORMATION:

Primary Insurance Company _____ Subscriber No. _____

Policy holder's Name _____ Relationship to Patient _____

Policy holder's Date of Birth _____ Policy holder's Social Security No. _____

Secondary Insurance Company _____ Subscriber No. _____

Policy holder's Name _____ Relationship to Patient _____

Policy holder's Date of Birth _____ Policy holder's Social Security No. _____

I hereby certify that the above information is true and accurate to the best of my knowledge.

(Date) Signature of Patient (Parent or guardian if minor)