Last Name	First	Nickname	(Circle one) Mr. Mrs. Dr Ms. Miss	Home Phone
Home (street) Address				Work Phone
City & State		Zip Code	Spouse's Name	Spouse's Work Phone
Date of Birth	Age	Social Security Number		Driver's License Number
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	Insurance Company: VSP MESC Medicare Superior Vision	
Name(s) of Children:				

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

Please checkmark ✓ any of the following which apply to you:

		Circle if Self or Family:	
☐ Blur, strain, discomfort at far	☐ Double vision	☐ Blindness	S F
☐ Blur, strain, discomfort at near	☐ Eye disease	☐ Glaucoma	S F
☐ Tired or sleepy from reading	☐ Eye surgery	☐ Cataracts	S F
☐ Frequent headaches	☐ Eye ulcer	☐ Diabetes	S F
☐ Sensitive to bright lights	☐ Skull fracture or concussion	☐ High Blood Pressure	S F
☐ Have taken eye exercises		☐ Arthritis	S F
☐ Have worn contact lenses	☐ Crossed or turned eye		

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 checkmark ✓ those VISUAL TASKS that you do often:

☐ Deskwork	☐ Prolonged reading	☐ T.V
☐ Computer Work	☐ Golfing	☐ Movies
☐ Bookkeeping/ Accounting	☐ Driving / Biking	☐ Theatre
☐ Artwork / Craft	☐ Fishing	☐ Dining Out
☐ Typing	☐ Jogging / Walking	☐ Cards
☐ Sewing / Needlework	☐ Swimming / Beachgoing	☐ Shopping
☐ Cooking	☐ Skiing	☐ Dancing

Other VISUAL TASKS not listed _____

Are you interested in contact lenses? ☐ Yes ☐ No

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** _____