



WELCOME BACK TO OUR OFFICE

NAME _____ DATE _____ LAST EXAM _____ AGE _____

STREET _____ CITY _____ STATE _____ ZIP _____

P.O. BOX _____ DATE OF BIRTH _____ S.S # _____

HOME# _____ WORK# _____ CELL# _____

EMAIL _____

EMPLOYER _____ EMERGENCY CONTACT _____

VISION INSURANCE _____ MEDICAL INSURANCE _____

****IF YOU ARE ON MEDICAID OR PEACHCARE AND HAVE OTHER INSURANCE COVERAGE, PLEASE LET THE RECEPTIONIST KNOW.**

OTHER FAMILY MEMBERS

SPOUSE _____ AGE _____ NAME _____ AGE _____

NAME _____ AGE _____ NAME _____ AGE _____

CURRENT MEDICATIONS:

ARE YOU CURRENTLY WEARING GLASSES _____ OR CONTACTS _____

ARE YOU EXPERIENCING ANY PROBLEMS WITH GLASSES OR CONTACTS? YES NO
IF YES WHAT KIND _____

ARE YOU INTERESTED IN CONTACTS? YES NO

ARE YOU INTERESTED IN INFORMATION ON A NON-SURGICAL PROCEDURE TO REDUCE OR ELIMATE THE NEED OF GLASSES? YES NO

DO YOU WORK WITH A COMPUTER? YES NO

METHOD OF PAYMENT CHECK _____ CASH _____ CREDIT CARD _____ MEDICAID _____

THANK YOU!