Account #:_____ **PLEASE PRINT**

Patient: _____ _____ _____ Age: _____ Birth date: ____/____/____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone: _____ Cell Phone: _____

Social Security #:_____ | _____ | _____ e-mail address: _____

Address: _____

_____ _____ _____
(CITY) (STATE) (ZIP CODE)

OCCUPATION: _____ BUSINESS PHONE: _____

EMPLOYER: _____

SPOUSE'S NAME: _____ OCCUPATION: _____

SPOUSE'S EMPLOYER: _____ BUSINESS PHONE: _____

RESPONSIBLE PARTY (IF MINOR): _____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE ADULT: _____

PREFERRED CONTACT PERSON: _____ **TELE #:**_____

MEDICAL INSURANCE COMPANY: _____

_____ _____
NAME OF PRIMARY HOLDER OF INSURANCE **DATE OF BIRTH OF PRIMARY HOLDER**

DOES THE PATIENT CURRENTLY WEAR **GLASSES**? ☐YES ☐ NO; **CONTACT LENSES**? ☐ YES ☐ NO

HOW OLD IS THE CURRENT PRESCRIPTION YOU ARE WEARING? _____

KNOWN MEDICAL PROBLEMS: _____

_____

REFERRED BY: _____

PHONE # _____

NAME OF **PRIMARY CARE DOCTOR**: _____ FAX # _____

YOUR DRUGSTORE'S NAME: _____ PHONE # _____