Mr.Ms.Mrs.Miss:_____ Sex: M F **Birthdate**: _____ Age: _____

Home Address: _____ City: _____ Zip Code: _____

Home Phone ( ) _____ Business / Cell Phone ( ) _____

Email Address: _____ **Best way of contacting you?** _____

Occupation: _____ Employer: _____

Do you drive_____ smoke_____ drink alcohol_____ illegal drugs____ Date of last physical_____

Marital Status: M S WID DIV Spouses Name: _____ Phone#:_____

Referred By: _____ Phone# :( )_____

Person Responsible for Account: _____ Relationship: _____ Phone#: ( ) _____

Emergency Contact: _____ Phone#: ( )_____

Primary Insurance: _____Group#:_____

Medicare #:_____ Medi-Cal #:_____

Policy #:_____ **SS#:_____**

Secondary:_____**VISION INSURANCE**:_____

Did you sustain an injury at work? Y N Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N Is your spouse or other family member employed? Y N

Are you currently employed? Y N Do you have a secondary insurance Policy? Y N

Does anyone in your family or you have:

Glaucoma___ Macular Degeneration___ Retinal Detachment___ Blindness___ Diabetes___ Other_____

Cataracts___ Corneal ulcer___ Iritis/uveitis___ Crossed eyes___ Lazy eye___ Dry eyes___

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature Date

A NO SHOW TO AN APPOINTMENT WILL RESULT IN A $35 EXAM CHARGE OR $100 PROCEDURE CHARGE UNLESS YOU RESCHEDULE OR CANCEL APPOINTMENT WITHIN 24 HOURS OF YOUR APPOINTMENT TIME.