FIRSTEYECARE
Vision Made Clear

Name Last _____ First _____ M.I. _____

Address _____ City _____ ST _____ Zip _____

Birthday _____ S.S. # _____ Driver's License # _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail Address _____

Employer _____ Occupation _____

Spouse Name or Parents if Minor _____

Names / Ages of dependents _____

INSURANCE INFORMATION

Vision Insurance _____ Medical Insurance _____

Insured's Name _____ Relationship to patient _____

Birthday _____ S.S. # _____

Employer _____

Is a Referral required from your PCP? **YES** **NO**

Primary Care Physician _____ PCP Phone _____

Last Eye Exam _____ Doctor _____

Do you wear glasses?	YES	NO
Do you wear contact lenses?	YES	NO
Are you interested in contact lenses?	YES	NO
Do you use a computer?	YES	NO

Are you allergic to any medication? YES NO

If yes, please list below

_____

Medications you are currently taking:	To Treat Condition:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____