Name:_____ Date of Birth:_____

Address:_____State:____ Zip:_____

Phone:_____ Cell:_____ Work:_____

Email Address:_____ Last Eye Exam:_____

Employer:_____ Occupation:_____

Employer Address:_____ State:___ Zip:_____

Social Security Number:_____

Vision Insurance Company

Insurance Co._____

Member Name:_____

Address:_____

Member Birth Date:_____

Medical Insurance Company

Insurance Co._____

Member Name:_____

Address:_____

Member Birth Date:_____

Our doctors are concerned with your vision and also the medical health of your eyes. For that reason they may decide to do additional medical tests along with your routine eye exam. These tests will be billed to your medical insurance and may be applied to your deductible. In that case, you will be responsible for these charges.

___ I understand, and give permission for any necessary medical tests.

___ I just want a routine vision exam. I do not want the doctors to perform any medical tests.

_____ _____

Signature Date