Name:_____ Date_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Home:_____ Cell:_____ Work:_____

E-mail:_____

Insurance: VSP Medicare Medical Mesc Delta Health Claims Central Private
Other:_____
S.S._____-____-_____ Birthday_____ □M □F Married ? yes no

Occcupation _____ Employer:_____

Do You Wear Contacts? Yes No Age of current
RX?_____
Do You Wear Glasses? Yes No Age of current pair**?**_____

Alcohol Use ? None < 1 per day 1-2 per day 3 or More
Do You smoke? Yes No Daily use: occasional ½ pak 1 pak _____
amt.
Former Smoker? Yes No Quit when? _____

Please list any **medications** you are currently taking: None □

_____ Purpose?_____ _____Purpose?_____

_____ Purpose?_____ _____Purpose?_____

_____ Purpose?_____ _____ Purpose?
_____
(More? Please List on back)

List serious allergies to medications: None □

_____ _____

Who is your general physician**?**
Name_____

City of Practice_____ Last Visit Date:_____

Communication Preference : e-mail□ Phone □ Mail □

Meaningful Use: Race:_____ Ethnicity:_____

Preferred Language_____

Who May We Thank For Your Referral?_____

Signature_____