

Are you currently experiencing?				Visual Symptoms			
Yes		No		Yes		No	
Skin rash				Blurred distance vision			
Skin lesions				Blurred reading vision			
Heartburn				Blurred computer vision			
Abdominal Pain				Eyes water, itch, or burn			
Arthritis				Lost or broke glasses			
Weakness				Flashes or floaters			
Easily broken bones				Problem with present contact lenses			
Depression				Want contact lenses			
Nervousness				General check up			
				Other			
When was your last...							
Eye examination				Doctor			
Medical examination				Doctor			
List medications that you are currently taking.							
1.				4.			
2.				5.			
3.				6.			
Please circle the products that you are interested in.							
Sunglasses	Ultraviolet radiation protection	Computer glasses	Thinner, lighter lenses				
Invisible bifocals	Lenses that change in the sun	Sports glasses	Tint				
Our office policy:							
1. Fees for service are due at the time of service. This includes deductibles and co-pays. There are additional fees for contact lens related services.							
2. Insurance agreements are between you and your insurance company. We will assist you with our expertise and experience in obtaining payment, but ultimately, you, the patient are responsible for your bill.							
3. Any materials ordered (glasses or contact lenses) require a 50% deposit, exclusive of insurance benefits. This is non-refundable once the materials are ordered.							
4. There are no refunds or credits for materials left in our office for more than 60 days .							
5. There are no exceptions , so please don't force us to refuse your request.							
I understand the above office policy. I authorize the release of any medical information to all of my insurance companies. A copy of this form may be used as authorization. I also understand that if my account is sent to collection, that I will be responsible for all legal fees, collection fees, and interest on my account.							
Signed				Date / /			