

Full Legal Name _____ Nickname _____

Address _____

City/State _____ Zip Code _____

Home Phone _____ Grade _____ Birth date _____ Male Female

Father/Guardian _____ Work phone _____

Mother/Guardian _____ Work phone _____

Whom may we send a thank you to for your referral? _____

or did you find out about us through: **Location Sign Insurance Phone Book Internet Search**

Who is responsible for payment? _____

Do you have: Vision Insurance _____

Medical Insurance _____

Medical and Eye History for Child/Young Adult

When was your last eye exam? _____ Do you wear: **Glasses Contacts Neither**

Are you interested in Contact Lenses? **Yes No Not Sure**

Prematurity of Birth? **Yes No Not Sure**

List health conditions: _____

Please list your medications: _____

Please list any medications that you are allergic to: _____

Does anyone related to you have: **Diabetes High Blood Pressure Glaucoma Macular Degeneration**

Have you ever had an: **Eye Injury Eye Surgery Eye Disease**



Thank You!