WELCOME TO TSO CYPRESS

PERSONAL INFORMATION

Title: Mr/Mrs/Ms/Miss/Dr/Rev | Last Name: | First Name: | Middle: | Nickname:

Address: | City: | State: | Zip:

Home Phone: | Work Phone: | Cell Phone: | Other Phone:

SSN#: | Birthdate: | Sex: Male/Female | Email:

Marital Status: Single/Married/Divorced/Widowed/Child | Name of Spouse if Married (Name of Parent if Child):

Occupation: | Employer (School Name if Student): | If student: Full-time/Part-time

Hobbies or Special Needs (ex: sports, computer use, etc):

MEDICAL HISTORY

Name of Primary Care Physician: *Date of last visit to your PCP: Name of Last Eye Doctor:* **Date of Last Eye Exam***

Please List Any Medical Conditions You Are Being Treated For, And For How Long?

Please List Any Medications or Drugs You Are Currently Taking:

Please List Any Medication Allergies You Have Had:

Please List Any Eye Conditions You Have Had or Currently Have (including any past eye injuries or surgeries):

Do you have a **FAMILY HISTORY** of any of the following eye conditions:
[] Cataracts [] Glaucoma [] Macular Degeneration [] Other_____

Do you have a **FAMILY HISTORY** of any of the following medical conditions:
[] Diabetes [] Heart Disease [] High Blood Pressure [] Other_____

Are you interested in talking to the doctor about any of the following options:
[] Contact Lenses [] Overnight-wear Contacts [] Colored Contacts [] Multi-focal Contacts
[] Multi-focal glasses [] Polarized sunglasses []Transitions glasses [] Non-glare glasses
[] LASIK or other refractive procedures [] Vision therapy []Sports Vision therapy

Do you smoke? [] No [] Yes – how much?_____
Do you drink? [] No [] Yes – how often? _____
Do you do drugs? [] No [] Yes – how often? _____

How Did You Find Out About Our Office? [] Mailout [] Phone Book [] Walk By/Drive By [] TV/Radio
[] Direct Referral from: _____ [] Other:_____
[] Internet Search: [] Google [] Yahoo [] Bing [] Other:_____ [] Insurance Company

Office Policy:

1. All visits to the office are due and payable at the time of service.
2. Fees paid for services (ex. eye examination or contact lens fitting and evaluation) are non-refundable.
3. Fees for materials require a minimum 50% deposit. No refunds on eyewear: in-store credit only.

Please Sign to Authorize Treatment and/or Billing of your Insurance: _____
SIGNATURE Date: