

PLEASE PRESENT ALL INSURANCE CARDS

Patient Name	Today's Date
Date of Birth	Sex: □M □ F
Address 1	
	Zip
Phone Number(s) home:	cell:
Email Address	
Social Security Number	
Family Physican	
If Employed, Employer	
Job Title	Doctor's Recommendations
Hours of computer use	Anti-Glare
Hobbies	Anti-Glare
	ට් Other
Name of Parent/Guardian (if minor):	
Father	Mother
In an Emergency please contact:	
Phone#	<u> </u>
I have read and agree to the HIPAA and I	nsurance information.
Signature	Date
Signature(parent or guardian if minor)	Date