

## Welcome to our office!

To better serve you now and in the future, please complete this form as accurately and completely as possible.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Mobile Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Home Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Is it OK to contact you by:	Text message? Email?	<b>Yes</b> <b>Yes</b>	<b>No</b> <b>No</b>	Cell Phone? Home Phone?	<b>Yes</b> <b>Yes</b>	<b>No</b> <b>No</b>
-----------------------------	-------------------------	--------------------------	------------------------	----------------------------	--------------------------	------------------------

Do you have: <b>Circle one</b> If <b>yes</b> , please indicate who the carrier is:	Vision Insurance?	<b>No</b>	<b>Yes</b>	_____
	Medical Insurance?	<b>No</b>	<b>Yes</b>	_____
	Medicare?	<b>No</b>	<b>Yes</b>	_____
	Medicare Supplement?	<b>No</b>	<b>Yes</b>	_____
	TennCare?	<b>No</b>	<b>Yes</b>	_____

Remember, medical coverage may partially cover an eye exam if there is a medical reason to file (diabetes, cataracts, dryness, pink eye, etc.) Refraction and contact lens services are generally not covered. Co-pays and/or deductibles do apply and are collected at the time of service.

Drug Allergies: **No** **Yes** \_\_\_\_\_  
(Please list) \_\_\_\_\_

Are you taking any Medications? **No** **Yes** \_\_\_\_\_  
(Please list) \_\_\_\_\_

Any Major injuries surgeries, and/or hospitalizations? **No** **Yes** \_\_\_\_\_

Are you pregnant or nursing? **No** **Yes** \_\_\_\_\_

Do you wear Contacts? **No** **Yes** If so, Brand? \_\_\_\_\_  
Do you sleep in them? **No** **Yes**  
How often do you replace them? \_\_\_\_\_