SOKOL
ADVANCED EYECARE

First Name:_____Middle Initial:___Last Name: _____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____Cell Phone:_____

Date of Birth:_____Age:_____Male/ Female:_____

If a minor, parents/guardian name: _____

Email: _____Occupation:_____

Marital Status: Single:_____Married:_____Divorced:____Widowed:_____

Last Eye Exam:_____Where:_____

Have you ever tried contacts:_____If yes what kind?_____

Hobbies:_____

Approximate time per day on a computer:_____

Are you planning on getting new glasses on this visit?_____

Do you smoke:_____Alcohol usage if any:_____

Emergency contact info:_____

Current medications:_____

_____Pregnant or nursing:_____

Allergies to medications:_____Seasonal allergies:_____

Have you had any eye surgeries?_____

Family medical History: Cataracts, Diabetes, Glaucoma, Cancer, Thyroid, Hypertension:_____

_____

Insurance Information (If available)

Insurance Provider:_____ID and Group number:_____

Card Holders name: _____Date of Birth: _____