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?	**Yes**	**No**	Cell Phone?	**Yes**	**No**
	Email?	**Yes**	**No**	Home Phone?	**Yes**	**No**

Do you have: **Circle one** If **yes**, please indicate who the carrier is:				
	Vision Insurance?	**No**	**Yes**	____________________________
	Medical Insurance?	**No**	**Yes**	____________________________
	Medicare?	**No**	**Yes**	____________________________
	Medicare Supplement?	**No**	**Yes**	____________________________
	TennCare?	**No**	**Yes**	____________________________

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: (Please list) **No** **Yes** ____

____

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

____

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? _____________________