Entry Form

Name: _____ (Last) _____ (First) ___ (M) Today's Date: _____

Address: _____ Cell Phone: _____ _____

_____ (City) _____ (State) _____ (Zip) Consent to SMS messaging: ☐Y ☐N

Date of Birth: _____ Gender: _____ email: _____

Occupation: _____ Hobbies: _____

How many hours do you spend on phone _____ computer _____ and far away _____

I'm interested in: (write or check below) _____

Single vision glasses	☐	Color contacts	☐
Progressive glasses	☐	Contact lens	☐
Bifocal glasses	☐	Hard contacts	☐
Computer glasses	☐	Sport Goggles	☐
Office glasses	☐	Dry Eye treatment	☐
Multifocal Contacts	☐	Vision Therapy	☐
Prescription Sunglasses	☐	LASIK	☐

How did you find us or referred you to us? _____

Medical History:	Self	Family		Self	Family
High Blood Pressure	☐	☐	Lazy eye	☐	☐
Heart Disease	☐	☐	Eye turn	☐	☐
Cholesterol	☐	☐	Eye infection	☐	☐
Diabetes	☐	☐	Iritis	☐	☐
Thyroid	☐	☐	Glaucoma	☐	☐
Kidney	☐	☐	Macular Degeneration	☐	☐
Auto-immune	☐	☐	Retina	☐	☐
Arthritis	☐	☐			
Gastroenterology	☐	☐			

Other: (please write out): _____

Please List any Surgeries for eye or body: _____

Please List any medicatications: _____

_____ Allergies: _____

HIPPA

I, _____ (Legal name or patient's legal represenative), have been presented with Eye Eye Doc's notice of Privacy policy and have been offered a copy to keep for my records.

_____ (Signature) _____ (Date)

Technology Retinal Imaging

This quick, painless imaging helps detect early signs of eye diseases like glaucoma, macular degeneration, and diabetic retinopathy—often before you notice any vision changes.This optional service is just $39 out-of-pocket.

☐Yes ☐No

Please flip to the back page ---->

Insurance Info. (Disregard this section unless asked to fill out)

Name of Insurance: _____ Employer: _____

Member name if not yourself: _____ Member date of birth: _____

Member ID or last 4 of SSN: _____ Relationship to subscriber: _____
(self, parent, etc)

Optical and Contact Lens Policy

*We guarantee our glasses and lenses for at least one year. If there ever is a problem, bring them back and we will adjust, repair or replace as needed at no charge.

*We will remake a prescription at least once if you are having trouble adapting to a prescription at no charge.

*If you bring an outside prescription in and are having problem adjusting to the prescription, we will remake the lens if given a new prescription. If you prefer us to check your prescription at our office for a fee.

*Contact lens can be returned within 45 days if they are unopened. If they are opened we may be able to provide store credit or apply it to a new contact lens order.

All service and/or exam fees are nonrefundable

Prescription Release Ackwnoledgement Form

Sign below to acknowledge that you were provided with a copy of your eyeglasses prescription immediately after completing any refractive eye examination.

_____

Signature Date

Contact Lens Prescription Signed Acknowledgment Form

Sign below to acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting or when you finalize your contact lens trial either by paper or electronically via email.

_____

Signature Date

I consent that my eyeglasses and/or contact lens prescription may be sent electronically via email

☐ Yes ☐ No

Payment is due at the time of treatment. Parents/guardians are responsible for all fees rendered for the treatments of a minor/child. I agree to the optical and contact lens policy. I understand that filing a claim with my insurance company does not relieve me of any responsibility for payment. I authorize the use of my signature on all insurance submissions.

_____

Signature Date

Please flip to the back page ---->