WELCOME TO NORMANDY OPTICAL

First Name_____ Last Name_____

Address_____ Apt._____

City_____ State_____ Zip_____

Home Phone_____ Cell_____ OK to text? _____
(Please indicate the phone number at which you would like to be reached)

E-Mail _____ Birthdate _____ Age_____

Family Doctor _____ Referred by _____

Vision Benefits Company_____ ID#_____

Health Insurance Company _____ ID# _____

Member Name _____Member dob _____last 4 of social_____

What is the reason for today's exam? _____

List any medical problems: _____

List all medications you are currently taking: _____

List any drug allergies: _____

List any eye surgery/injury/disease in your past: _____

List any eye diseases in your family:_____

When was your last eye exam? _____

Do you currently wear glasses? _____ If so, how old are they? _____

Do you currently wear contact lenses? _____

Do you smoke or use tobacco products? _____

I hereby authorize Normandy Optical/ Dr Michael Wojton to furnish any information to insurance carriers concerning my eye exam/or treatment. I hear by assign Normandy Optical/ Dr Michael Wojton all payments for services rendered. I understand that I'm responsible for any amounts not covered by my insurance.
I acknowledge that I received a copy of Normandy Optical Notice of Privacy Practices.

Signature _____ Date _____