**Dr. Jay A Keesling**

**Welcome To: 20/20 Vision Center**

In order that we may serve you better, please print the following form information:

Mr. Mrs. Ms. Dr. _____.
(Last) (First) (Middle)

Mailing Address _____.
(Street or P.O. Box) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Would you like to sign up for our mailing list and receive promotions via email: Circle Y or N

Birthday: Mo. Day Year Age: ____ Male Female Email address: _____

Drivers Lic. No._____ Employer: _____

Name of family physician:_____ Soc. Sec. #_____

Whom may we thank for referring you to our office: _____
Last exam was_____years ago. Present prescription in glasses is_____years old.
Are you interested in contact lenses? _____ Do you presently wear contact lenses? _____

Please check all that apply. If it does not apply to you, leave it blank.

1) Ever had any injuries to your head or eyes? _____
2) Ever had any eye diseases or infections? _____
3) Do you see floaters or flashes of light? _____
4) Ever had eye surgery? What type? _____
5) Is there any history of glaucoma in family? _____
6) Have you ever been diagnosed as diabetic? _____
7) Have you ever been told you have cataracts? _____
8) Do you ever see double?_____
9) Does sunlight often bother you without sunglasses? _____
10) Does lighting in offices/stores seem too bright? _____
11) Do you have any allergies, including drug allergies? Type_____
12) Do your eyes frequently (Circle those which apply) Itch, Burn, Water, or Tire
13) Do you currently have or ever been treated for high blood pressure? _____
14) Are you presently having headaches? Describe where it hurts:_____
15) How often do you have these headaches? _____

Please describe your general health-listing any physical problems: (If you need more room use back of sheet)
_____
_____

Please list any medications which you are currently taking: (If you need more room use back of sheet)
_____
_____

For Medicare only: Please circle one--- Married, Single, Widow, Widower.

I understand that I am responsible for my bill. I authorize payment direct to my doctor.
I authorize use of this form on all Insurance submissions. I authorize release of information to all my Ins. Companies.
I authorize my doctor to act as my agent in helping me obtain payment for my Insurance Companies.
I permit a copy of this authorization to be used in place of the original. Date: _____

_____ _____
Medicare Signature (As signed on card) Medicare Number and Letter

**Secondary Insurance:**

Name of Insurance Co.:
_____
ID#:
_____
Address of Insurance Co.:
_____
_____
Insurance Company Ph #: