Welcome to Racine Optical Co.

Date:____________________

Last Name:____________________________First Name:_______________________ MI:______

Date of Birth:______________________ Address:____

City:____ State:____________ Zip:________________

Best Phone:_______________________________________ SSN:____________________________

Email: __________________________________ Employer/School:__________________________

Married: Yes___ No___ Emergency Contact Person:______________________________________

Insurance Subscriber's Name & Date of Birth ____

Are you having problems with your current contacts or glasses? _____________________________

Main purpose of your visit today? Eye Glasses Contacts Eye Health

Payment Policy:
Eye-wear and Contact lenses-50% down-payment is required on all purchases with remaining balance to be paid at dispensing. Every pair of eye-wear is custom made for your eyes, so returns are subject to a 30% restocking fee.

Professional Services- Payment in full is expected at the time of service. If you have vision and/or health insurance, we will submit a claim for you. The balance on your account will remain your responsibility.

I agree and understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any service rendered. I authorize the release of any information necessary to process my insurance claim.

Signature_______________________________________ Date___________________

OVER
PLEASE

Medical History

*Do **YOU** or any of your **FAMILY** have the following conditions?*

Conditions	***YOU***	***FAMILY***	***Parent, Grandparent, Sibling***
Blindness	____	_______	__________________
Cataracts	____	_______	__________________
Glaucoma	____	_______	__________________
Lazy Eye	____	_______	__________________
Retinal problems	____	_______	__________________
Diabetes	____	_______	__________________
Macular Degeneration	____	_______	__________________

*Have **YOU** ever been diagnosed or treated for any of the following?*

Corneal Abrasion	____	Allergies	____
Eye Injury	____	Cancer	____
Eye Infection	____	High Blood Pressure	____
Iritis/Uveitis	____	High Cholesterol	____
Lasik/RK	____	Thyroid Problems	____
Retinal Detachment	____	Other Medical Issues _____________________	

Name of family physician___________________ Date of last physical exam___________________

Current medications (Rx or over the counter)

____

____

____

____

Do you have any medication allergies Yes No

if yes please list____

Patient Eye History

Date of last eye exam______________

*Do **YOU** experience the following?*

___Blurry Vision	___Burning Eyes	___Tearing	___Headaches
___Double Vision	___Flashes of Light	___Grittiness	___Floaters
___Itchy Eyes	___Dryness	___Sunlight Sensitivity	
___Crossed Eye / Eye Turn	___Trouble Seeing at Night	___Uncomfortable Glasses	

*Do **YOU***

____Work at a computer? _____ Hours/Day

____Think you'd benefit from thinner, lighter lenses?

____Spend time outdoors?

____Have prescription sunglasses?

____Want information on Laser Vision Correction surgery?

____Have children or family in need of eye care?

____If you wear bifocals, do the lines or head tilting bother you?