



Returning Patient Form

Today's Date _____

Name _____
(last) (first) (mi)

Email address _____

ANY CHANGES.....IN:

Home Address City Zip _____

Cell Phone _____ Work _____ Home _____

Eye Care Insurance _____

Major Medical Insurance _____

Your Health _____

Medications _____

Do you use any eye drops? _____

Are you buying glasses or sunglasses today? YES NO ONLY IF Rx CHANGES

Do you currently wear contact lenses? YES NO

Do you currently wear high definition iZON lenses? YES NO

Are you interested in laser vision correction? YES NO

List any problems you are having with your eyes or your vision

Professional fees are due at the time of service and are not refundable. I understand that I will be responsible for fees not covered by insurance. I have been offered a copy of the Notice of Privacy Practices.

Signature _____

(If patient is under 18 years of age, parent or guardian signature required)