

DR. PAUL J. SUPER, O.D., F.A.A.O. P.C

Name _____

Title: Mr. Ms. Mrs. Dr. Prof. or _____

Address _____

SS # _____

City _____ Zip _____

Driver's License# _____

Phone (home) _____

Occupation _____

Phone (work) _____

Where would you prefer to be contacted? Work home day eve weekend

Cell phone _____

E-mail address _____

Date of birth _____

Company name _____

Medical insurance _____

Vision insurance _____

Spouse's name _____

How did you hear about us? _____

Last eye exam _____

| | | |
|-----------------------|----------|------|
| Interested in: | | |
| Glasses | Contacts | Both |
| LASIK | Vitamins | |

Any contact lenses? _____ How old are they _____: uncomfortable, blurry, dry, itchy, torn, or lost

Any prescription glasses? _____ How old are they _____: thick, heavy, scratched, broken, blurry, or lost

With your glasses or contact lenses, is distant vision: ___ fuzzy ___ doubled ___ a strain ___ good

With your glasses or contacts lenses, is near vision: ___ fuzzy ___ doubled ___ a strain ___ good

Have you been suffering from headaches recently? _____ When _____

Have you experienced any type of eye pain or injury? _____ Where _____

Current medication use _____

Do you or your blood family suffer from?

| | | | | |
|---------------------|-----|----|------|-------|
| Heart disease | yes | no | whom | _____ |
| High blood pressure | yes | no | whom | _____ |
| Diabetes | yes | no | whom | _____ |
| Glaucoma | yes | no | whom | _____ |
| Eye disease | yes | no | whom | _____ |

Payment is due when the services are rendered. You are responsible directly to our office for payment. Our office does not accept responsibility for collection of insurance claims. However, we will assist you in preparing any necessary forms for your medical insurance.

There is a cancellation policy in which an appointment must be cancelled 24 hours prior.

All patients who do not honor our policy will be charged a \$65.00 fee.

We are here to help you through comfortable, clear, and healthy vision.

Welcome to the office.

Patient signature _____

Date _____