

Please check the conditions that apply to you or that run in your family

Allergies	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Lazy eye	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Respiratory disease	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Turned eye	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Cancer	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Color "blind"	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Diabetes	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Light sensitive	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Drug sensitive	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Eyestrain	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Elevated cholesterol	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Dry eyes	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Heart problem	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Floater/spots	<input type="checkbox"/> Self	<input type="checkbox"/> Family
High blood pressure	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Flashing lights	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Thyroid	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Retinal detachment	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Migraine or headaches	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Blindness	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Head trauma	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Cataracts	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Macular degeneration	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Glaucoma	<input type="checkbox"/> Self	<input type="checkbox"/> Family
			Eye surgery or injury	_____	

In what recreational activities do you participate? (Circle all that apply)

read racquetball tennis gardening golf baseball swim camp sew play cards
 flying video games musical instrument other _____

Do you wear any special or protective eyewear for your sport? Y N

Does your vision, or do your lenses, interfere with any activity? Y N

Payment terms: We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum of 50% deposit is required and the balance is due upon delivery. We accept cash, personal checks, Visa, Mastercard, and Discover. I have read and agree to all the provisions of the office financial policy.

Signature _____ Date _____

Initial	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I acknowledge that I received a copy of
 Julia B. Edwards, O.D. & Trixie I. Eakin, O.D.
 Notice of Privacy Practices.
 Date _____
 Signature _____