PATIENT NAME:_____

RESPONSIBLE PARTY (if a minor):_____

HOME PHONE:_____**CELL PHONE:**_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP:**_____

BIRTHDATE:_____**AGE:**_____**SEX: MALE**_____ **FEMALE**_____ _

SOCIAL SECURITY NO:_____

SINGLE:_____**MARRIED:**_____**DIVORCED:**_____**WIDOW:**_____

PLACE OF EMPLOYMENT:_____**WORK PHONE:**_____

SPOUSE NAME:_____

SPOUSE EMPLOYMENT:_____**SPOUSE WORKPHONE:**_____

FAMILY DOCTOR:_____

REFERRING PHYSICIAN:_____

CARDIOLOGIST:_____

KNOWN MEDICAL PROBLEMS:_____

MEDICATION TAKEN DAILY:_____

_____

MEDICINE ALLERGIES:_____

ARE YOU CURRENTLY WEARING CONTACT LENSES?:_____

IN CASE OF EMERGENCY PLEASE NOTIFY:_____

TELEPHONE NUMBER:_____

PURPOSE OF VISIT:_____

Dr. Stoken/Dr. Wagner participates in a variety of insurances. Please present your insurance cards/forms you have available at every visit. Thank you.

PATIENT'S SIGNATURE_____