Michael E. Jacobs O.D.

Welcome To Our Office

Full legal name _____

Nickname or name you prefer _____

Date of birth _____ SS # _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____E-mail _____

Spouse's name if married _____

Parent's name if child _____

Employer/school _____ Occupation/grade _____

Describe job duties _____

Retired? What was your occupation _____

How much do you use a computer _____

Hobbies, recreation and activities _____

Last vision exam _____ Last eye doctor _____

Do you now wear, or have you ever worn glasses? _____ Contact lenses? _____

What type of Contacts Lens?Hard/Gas permeable/Soft/Soft for astigmatism: Daily wear/Extended Wear

Have you had any problems wearing contact lenses? _____

Are you interested in wearing contact lenses? _____ Refractive surgery? _____

Preferred method of payment: Cash/Check Credit card Insurance Medicare Medi-Cal Other

Vision insurance plan _____ Medical insurance plan _____

Why did you select our office? patient referral doctor referral insurance list yellow pages

web site live nearby drove or walked by other _____

Whom may we thank for referring you to our office _____

THANK YOU FOR SELECTING OUR OFFICE