Dr. Maurice E. Zadeh, Optometrist and Associates

Welcome Back To Our Office

Please fill out the information requested so that we may better serve you. Please print. Thank you.

Name: _____ _____ Date of birth: _____/_____/_____
Last First Month Day Year

Address: Same or Changed _____
(please circle one)

_____ _____ _____
City State Zip

Home: _____ Work: _____ Cell: _____

Email: _____

Insurance Company Name / Customer Service Number / Identification Number:

_____

Business / Work Name, Address, and Phone number:

_____

Changes in Medical History / Medications:

_____

Problems with Present Glasses and/or Contacts:

_____

Problems with Vision – Distance and/or Near (please specify):

_____

Diagnosis Issues

Do you have one or more pair of current glasses?	Yes	No	N/A
Do you work on a computer for long periods of time?	Yes	No	N/A
If you wear glasses, would you benefit from thinner and lighter lenses?	Yes	No	N/A
If you wear bifocals, are you bothered by restricted areas, lines, or head-tilting?	Yes	No	N/A
Are you bothered by glare when you drive at night?	Yes	No	N/A
If you wear contacts, are you happy with your vision and/or comfort?	Yes	No	N/A
If you have not worn contacts before, would you be interested in a "test drive" of the latest in contact lens design?	Yes	No	N/A
Do you desire information regarding laser vision correction (Lasik) and/or a FREE evaluation regarding your candidacy?	Yes	No	N/A
Are you interested in information regarding "Ortho-K," a non-evasive, non-surgical procedure that can eliminate the need for glasses/contacts during the day?	Yes	No	N/A