ACQUAINTANCE FORM

NAME _____ TELEPHONE (HOME) _____

PARENT NAME (if minor) _____ TELEPHONE (BUSINESS) _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

DATE OF BIRTH _____ AGE_____ SEX_____

OCCUPATION _____ EMPLOYER _____

FAMILY PHYSICIAN _____ REFERRED BY WHOM ? _____

DO YOU HAVE VISION CARE INSURANCE YES_____ NO_____

NAME OF INSURANCE PROGRAM & EMPLOYED BY WHOM _____

NAME OF INSURED EMPLOYEE _____

SOCIAL SECURITY NUMBER _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____