

VISION CARE STATEMENT

- (1) Patient's nameAge.....
- (2) Nature of eye condition or injury necessitating service (Describe fully)
- (3) If due to an eye injury, did this injury arise out of patient's employment? Yes.....No.....
- (4) Describe fully services rendered using one line for each operation, prescription or service.

SERVICE	DATE SERVICE PERFORMED	FEE CHARGED
COMPLETE EXAMINATION		
LENSES (GIVE TYPE) <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> TRI-FOCAL <input type="checkbox"/> CONTACT		
<input type="checkbox"/> BI-FOCAL <input type="checkbox"/> LENTICULAR <input type="checkbox"/> OTHER (DESCRIBE)		
FRAMES		
TOTAL AMOUNT CHARGED		
AMOUNT PAID ON TOTAL CHARGED		

- (5) Were any services rendered in connection with medical or surgical treatment? Yes.....No.....
- (6) If conventional glasses were prescribed, answer the following questions:
- a) Are the glasses tinted and prescribed for outdoor wear only? Yes.....No..... Tint No.....
- b) Is the replacement (lens or frame) necessary due to theft, loss or breakage? Yes.....No.....
- (7) If contact lenses were prescribed, answer the following questions:
- a) Were the lenses prescribed following surgery? Yes.....No..... Date of surgery.....
- b) Did the lenses improve the visual acuity in the better eye to 20/70 or better? Yes.....No.....
- c) Could the improvement be made with conventional glasses? Yes.....No.....
- d) Is this a replacement contact lens? Yes.....No.....
- Is the replacement necessary due to changes in the better eye? Yes.....No.....
- If so, is the vision in the better eye correctable to 20/70 or better with the lens used prior to the replacement? Yes.....No.....
- Does the replacement lens correct the visual acuity to 20/70 or better? Yes.....No.....
- (8) What other services, if any, did you provide patient? (Itemize, giving dates and fees).....
- (9) The patient has been unable to perform his regular or customary work from.....through.....
If still unable to perform his regular or customary work, when should patient be able to resume such work?.....

DATE	PHYSICIAN'S NAME (PRINT)	DEGREE	INDIVIDUAL PRACTITIONER'S SS
	PHYSICIAN'S SIGNATURE	TELEPHONE	ALL OTHERS - EMPLOYER I.D.
MUST BE FURNISHED UNDER AUTHORITY OF LAW			
STREET ADDRESS		CITY OR TOWN	STATE OR PROVINCE ZIP CODE