Dr. Chris Olson
320 McKenzie Ave. Ste. 206 • Council Bluffs, IA 51503
Phone: (712) 256-1111 • Fax: (712) 256-1549

Last Name:______________________________ First Name:__________________________________

Date of Birth:__________________ Gender: ❑ M ❑ F SS#:__________________________

Street Address:____ Unit/Apt: ______________

City:____________________________ State:______________ Zip Code:________________________

Cell Phone:________________________________ Home Phone:______________________________

Work Phone:______________________________ Email Address:_____________________________

Employer:________________________________ Occupation:__________________________________

Family Physician/Pediatrician:____

Who can we thank for referring you to our office? ____

Emergency Contact Information:

Name:_______________________ Relationship:______________ Phone:_____________________

Please complete information below for the Insurance policy holder:

Last Name:______________________________ First Name:__________________________________

Date of Birth:__________________ Gender: ❑ M ❑ F SS#:__________________________

Contact Phone:___________________________ Email Address:______________________________

Employer:________________________________ Occupation:__________________________________

- Do you occasionally experience dry eyes? ❑ Yes ❑ No
- Are your eyes sensitive to sunlight? ❑ Yes ❑ No
- Do you experience glare issues while driving at night? ❑ Yes ❑ No
- Do you work at a computer? ❑ Yes ❑ No If yes, how many hours a day?__________________
- What type of outdoor activities do you enjoy?____
- Are you planning on getting eyewear or contacts today? ❑ Yes ❑ No

- ____ (Please initial) I have read and understood the HIPPA Form provided by Olson Eye Care.

Authorized Signature:____________________________________ **Date:**__________________

Email Form to Olson Eye Care | Print Form and Bring to Office