11421 E. CARSON STREET SUITE D
LAKEWOOD, CA 90715 (562)860-4590

Date:________________________

WELCOME TO LIVE LIFE OPTICAL!

CUSTOMER INFORMATION

Last Name:______________________ First Name:_________________________ Date of Birth:___________________
Month / Date / Year

Address:_______________________________________ City:_____________________CA, Zip Code________________

Email Address:____

How did you hear about us?
□ Yelp □ Insurance
□ Google □ Referral___________
□ Craigslist □ Dr___________
□ Drive By □ Walk-In □ Other__________

Home Phone: (_____)______________________________
Cell Phone: (_____)______________________________
Work Phone: (_____)______________________________

Occupation:____________________________________ at____

CUSTOMER'S EYE INFORMATION (Please circle yes or no)

Wear glasses	yes / no
Wear prescription sunglasses	yes / no
Wear contact lenses	yes / no

CURRENT EYEGLASSES INFORMATION: Select one or more

□ Single Vision Far □ Bifocal (w/line)
□ Single Vision Near □ Progressive (no-line)
□ Single Vision Computer □ Don't Know?

INSURANCE INFORMATION

Vision Care Plan: □ Yes □ No If Yes, name of plan: _____________________________________

Name of Insured (if different from customer): Last, First ____

Primary Insured's Social Security:______-______-_________ Birthday of Insured: ___________________
Insurance Card Member ID # ___________________________ Month / Date / Year

Customer's relationship to Insured: □ Self □ Spouse □ Child □ Domestic Partner

I understand that I am responsible for the amounts not covered by my vision insurance plan.
I authorize Live Life Optical to bill my insurance company for my eyeglasses/contact lenses order.

EYEGLASS PRESCRIPTION POLICY

I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each customer with their unique prescription. _______
Initial

For prescription we fill written by an Optometrist: Eyeglass lenses will be re-made one time at no charge if the prescribing doctor provides a new written prescription within 60 days of dispensing (Equal or lesser value.) _______
Initial

I understand a 50% deposit is required before any materials will be ordered. Deposits for materials not picked up in 90 days will not be refunded. _______
Initial

____ ____________________________________
Signature of Customer or Guardian Date