EYE LOVE
PROGRAM APPLICATION

CONTACT INFORMATION

Name ______________________________ Date ___/___/___ DOB ___/___/___

Name You Go By ______________________________ Phone ______________________________

City ______________________________ State ______________ Zip ______________

Email ______________________________

APPLICATION INFORMATION

Do you have medical insurance of any type? If so, please explain. ______________________________

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Do you have vision insurance? If so, please explain. ______________________________

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When was your last eye exam? ______________________________

From Who? Where? ______________________________

How old are your current glasses? ______________________________

Have you ever received care through the Eye Love Program at BCEC before? ______________________________

Are you currently at patient at BCEC? ______________________________

How did you hear about the Eye Love Program at BCEC? ______________________________

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Why do you feel you need care and/or eyewear through the Eye Love Program at BCEC?
Please be as specific as possible for complete consideration.

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* BCEC OFFICE USE ONLY *

Application Received ___/___/___ by______________________________

Application Reviewed ___/___/___ by______________________________

Materials Voucher: ☐ Materials Pre-Approved
☐ Materials at Discretion of Doctor

Exam Voucher: ☐ Approved ☐ Not Approved

Exam Scheduled For ___/___/___

Notes on Application ______________________________

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Notes ______________________________

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