J&J OPTICAL

CUSTOMER INFORMATION

Today's date:			
Last name:		First:	
Street address:		Birthday:	
P.O. Box:	City:	State:	ZIP Code:
How did you hear about us:			

❑ Facebook	❑ Instagram	❑ Radio	❑ Billboard	❑ Movie Theatre	❑ Friend/Family
❑ Other:					

HOW WE CAN CONTACT YOU

Please specify, with a star, which of these you would like us to use to contact you.

Home Phone		Facebook	
Cell Phone: text or call		Instagram	
Email		Other	

QUESTIONNAIRE

Is this your first pair of glasses?	❑ Yes ❑ No	If not, how many do you currently use?	
How many hours per day do you wear your glasses?		Are you sensitive to light?	❑ Yes ❑ No
What is your favorite thing about your old glasses?		What is your least favorite thing about your old glasses?	
Are you in and out of buildings all day?	❑ Yes ❑ No	Do you have a useable pair of backup glasses?	❑ Yes ❑ No

At which distance do you usually use your glasses?	❑ Far away	❑ At arm's length	❑ Up close	❑ Other:	
If any, what brands do you like to wear?					
What are your favorite outdoor activities?	❑ Contact Sports	❑ Gardening	❑ Fishing	❑ Other:	
What are your favorite indoor activities?	❑ Watching Television	❑ Reading	❑ Sewing / Knitting	❑ Computer / Video Gaming	❑ Other:
How much time do you spend driving at night?	❑ Rarely	❑ Sometimes	❑ A lot	❑ Not at all	
How much time do you spend each day at the computer?	❑ Less than an hour	❑ A few hours	❑ All day	❑ Other:	
How long are you typically on electronic devices per day?	❑ Less than an hour	❑ A few hours	❑ All day	❑ Other:	
Is there anything else that you would like us to know about your eye needs?					

The information provided is to help us better understand your vision care needs. The contact information is only so we can contact you when the job is completed. We will not post or use your information unless told to do so.

Customer signature	*Date*