

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____

Last Name _____

First Name _____ MI _____

Street _____

City _____ State _____ Zip Code _____

SSN _____ DOB _____

Age _____ Sex M F

Home Phone _____

Employer (or School) _____

Occupation (or Grade) _____

Work Phone _____

Single Married Divorced Separated Widowed

Email Address _____

Spouse (or Parent's) Name _____

Spouse (or Parent's) Work _____

Date of Birth _____ Age _____

What is the major purpose of this visit? _____

Any problems with your current contact lenses or glasses? _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

Another Dr. Insurance List

Saw Sign/Building Newspaper/Radio/TV

Yellow Pages: Which directory? _____

Web Page: Which Web Site? _____

Other _____

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____ DOB _____

ID# _____ Grp# _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____ DOB _____

ID# _____ Grp# _____

Secondary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____ DOB _____

ID# _____ Grp# _____

Do you participate in a flex spending account? Yes No

How will you settle your account today? Cash Check Credit Card

Assignment And Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me, for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Lifestyle Questions

Do you..... (check box if your answer is yes)

..Work at a computer? If yes, please complete computer questionnaire.

..Think you might benefit from thinner, lighter lenses?

..Have interest in the latest contact lens designs

..Spend time outdoors? How much? _____ (Hrs/week)

..Have prescription sun wear?

..Prefer not to wear your glasses at times?

..Want information on Laser Vision Correction surgery?

..Have interest in a non-surgical approach to vision correction?

..Have more than 1 pair of current Rx eyewear?

..Have children?

..Have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following?

<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Corneal Abrasions	<input type="checkbox"/> Crossed/Turned Eye	<input type="checkbox"/> Tearing
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Floaters/Spots	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Headaches	<input type="checkbox"/> Iritis/Uveitis	<input type="checkbox"/> Itchiness
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Sunlight Sensitivity	<input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Occasional dryness	<input type="checkbox"/> Retinal Detachment	
<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Uncomfortable glasses	
<input type="checkbox"/> Other eye disorders _____		

Our Mission is to provide a lifetime of healthy vision for all our patients by providing professional and compassionate care with the latest technology.

