Patient Information (As it appears on your Insurance Card)

Name: Last_______________________ First _______________________ MI__________ Gender: M / F

Home Phone_____________ Cell______________ DOB_______________ Marital_______ SS#____________

Home Address_____________________________ City_______________ State______ Zip Code__________

Vision Insurance Co._________________________ ID#______________

Medical Insurance Co._________________________ ID#_________________________ Group #__________

Supplemental Insurance Co. (Medicare Patients) ___________________________

Reason for today's visit____

Personal and Social History

Date of Last Eye Exam:_________________________ Doctor Name _________________________

Occupation______________________ Primary Care Doctor:_______________ Date of last visit__________

E-mail_________________________________

Previous patient? Yes / No How did you hear about our office:__________________

Hobbies_______________________ Computer use_________________________

Do you currently wear glasses? Yes / No Age of Current Glasses ___________ Do you wear sunglasses? Yes / No

Contact Lens History

Have you ever worn contacts: Yes / No Are you Interested in contacts? Yes / No / Maybe

If no, please explain:________________________________

What brand do you wear?___________________ Brand of solution_______ Do you use drops?_______

How often do you change your lenses? Daily Every 2 weeks Monthly Other__________

Do you sleep in your contacts? Yes / No If Yes, How often____________________

Fitting and Follow up must be completed within 2 months in order to purchase contacts.

Release of information for patients OVER 18 years of age

Due to HIPAA regulations we require your written authorization to release any of your information. Please list individuals who you allow access to your information. This includes ordering contacts and picking up on your behalf.

Name:____ Relationship_____________________ Date__________

Name:____ Relationship:_____________________ Date__________

Fitting and Follow up must be completed within 2 months in order to purchase contacts. **OVER →**

FOR OFFICE USE ONLY:

Patient #____________ **Exam Copay**__________ **Exam**__________

Insurance____________ **Standard Fit Copay**__________ **CL Exam**__________

Vex / CL____________ **Premium Fit Copay**__________ **OptoMap**__________

Optos / Dilation / Neither **Contact Benefits**__________ **Contacts**__________

Medical Insurance________ **Total Paid**__________