

Established Patient Form

(Please print and fill out completely)

| Last Name | First Name | | MI |
|---|-----------------------------------|------------------------|-----------------------------------|
| DOB:/ Age: | Sex: Male / Female | SS#: | - |
| ** If using insurance, we <u>must</u> have your <u>Social Sec</u> | <u>urity Number</u> on file. Othe | rwise we will not l | be able to accept your insurance. |
| Address: | | | Apt # |
| City: | S | tate: | Zip |
| Home Phone: Work Ph | ione: | *Cell pho | one: |
| Employer /School : | Occupation: _ | | |
| About how many hours a day do you spend on the compu | iter? | - | |
| | | | |
| Email Address: | | | |
| | ormation is kept strictly confic | dential. Your email is | s NEVER shared.) |
| , , | , , | | , |
| Primary Insurance Information: | | | |
| Primary's Name (Not the name of your insurance compar | 1y): | | |
| Primary's DOB:/ | Primary's SS#: | | |
| Patient's relationship to Primary: SELF SPOUSE | CHILD OTHER | | |
| | | | |
| Optical History: | occos | □ Poth | |
| What is your primary Vision correction? | | □ Both | |
| Do you wear sunglasses or UV protection? Person plan on purphasing glasses today? | | - Voc if vocamena | سمامها |
| Do you plan on purchasing glasses today? | | ☐ Yes, if recomme | naea |
| Do you want to be fitted in contact today? Ye | es □ No | | |
| If you are currently wearing contacts: | | | |
| How often do you dispose of your contacts? | How many h | hours a day do you w | vear contacts? |
| What contact lens solution do you use? BioT | rue 🗆 OptiFree 🗆 Clear Car | e 🗆 Generic 🗆 Ot | her |
| How many days out of the week do you wear yo | our contacts? | | |
| Do you sleep overnight in your contacts? | ☐ Yes, how many day | /s? | |
| | | | |
| | | | |
| | | | |
| Patient / Guardian signature | | Date | |