

Welcome to VisionCare Specialists

Last Name _____ First Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Birth Date _____ Gender: M / F Email: _____
Home Phone _____ Work Phone _____ Cell Phone _____
Occupation _____ Employer _____ Hobbies: _____
Vision Insurance Name _____ Insured ID Number _____

Employment: Fulltime/ Part-time/ Self-Employed/ Retired/ Not Employed / Student: Full-time Part-time/ Unknown

Marital Status: Single / Married / Divorced / Widowed

If you are a new patient, how were you referred to us:

Vision Insurance Employer's Vision Program Another Patient: (who can we thank?) _____

Live in neighborhood Work in neighborhood Phone book Other: _____

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Glasses

On average, how many hours a day do you spend on a computer? _____ hours

Are you bothered by glare? Yes / No

Do you own prescription sunglasses or Transitions? Yes / No

Do you own more than one pair of glasses in case of an emergency (i.e., lost or broken)? Yes / No

Contact Lenses

If you wear/wore contact lenses: Current brand: _____ Previous brand: _____

How long have you worn contact lenses? Less than 1 year / 2 to 5 years / Longer than 5 years

How often do you replace your contact lenses? Daily / 2 weeks / 1 month / 1 year _____

How often do you sleep in your lenses? _____ times per week

Are you interested in color contact lenses? Yes / Maybe / No

Ever a reason that prevented you from wearing lenses? Yes / No, Reason: _____

Which solutions do you use? Aquify / Optifree / Renu / ClearCare / Complete / Generic brand / Any

Do you own a nice pair of glasses in case of an emergency (i.e., pink eye or eye infection)? Yes / No

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Are you interested in purchasing new glasses today? Yes / Maybe / No
Are you interested in purchasing new contacts today? Yes / Maybe / No

I authorize VisionCare Specialists to bill my insurance when possible. I understand that the amounts quoted are not a guarantee of benefits and that I may be financially responsible for charges not covered by my insurance. I authorize the use of my signature on all insurance submissions. I acknowledge that I was offered an opportunity to review or requested and received a copy of our Notice of Privacy Practice for Hippa.

Patient/Guardian Signature: _____ Date: _____