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:_____