Welcome Back!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date: ___________________________

Patient Information

Last: ____

First: ____________________MI: _______________

Street: ______________________________________

City: _________________________State: __________

Zip Code: ____________________________________

Home Phone: _________________________________

Work Phone: __________________________________

Cell Phone: ___________________________________

Email Address: __________________________________

How do you prefer to be contacted?

(Indicate #1 and #2 preference):

Home #___Work #___Cell #___Text___Email____

Date of Birth: ____________________Age: __________

Sex: M F

Employer (or School): ____________________________

Occupation (or Grade): ___________________________

Spouse (or Parent's Name): ________________________

Spouse (or Parent's Work): _________________________

Insurance Information

Vision Insurance:______________________________

Subscriber Name:______________________________

Subscriber SSN/ID#:____________________________

Subscriber Birth Date:__________________________

Primary Medical Insurance:______________________

Subscriber Name:______________________________

Subscriber SSN/ID#:____________________________

Subscriber Birth Date:__________________________

Any Changes in Medical & Vision history? Explain:

____

____

____

____

____

____

Do you participate in a flex spending account?

☐ Yes ☐ No

Lifestyle Questions

Do you…(check all that apply):

☐ …use digital devices on a regular basis? If yes, how many hours per day? ______hrs/day
☐ …think you might benefit from thinner, lighter lenses?
☐ …prefer NOT to wear glasses at times?
☐ …spend time outdoors? How often? ____hrs/week
☐ …participate in vision-related sports or other activities? If yes, please specify_________________________________

____

____