

# 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: \_\_\_\_\_

***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

<b>Are you interested in purchasing new glasses today?</b>	Yes /	Maybe /	No
<b>Are you interested in purchasing new contacts today?</b>	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: \_\_\_\_\_