CRYSTAL CLEAR IMAGE
EYECARE • OPTICAL

New Patient Form

(Please print and fill out completely)

_____, _____ _____

Last Name ***First Name*** ***MI***

DOB: _____/_____/_____ Age: _____ Sex: Male / Female **SS#: _____-_____-_____**

***** If using insurance, we must have your Social Security Number on file. Otherwise we will not be able to accept your insurance.***

Address: _____ Apt #_____

City: _____ State: _____ Zip_____

Home Phone: _____ Work Phone: _____ ***Cell phone**: _____

Employer**/School**: _____Occupation: _____

About how many hours a day do you spend on the computer? _____

Email Address: _____

(NOTE: All patient information is kept strictly confidential. Your email is NEVER shared.)**

Primary Insurance Information:

Primary's Name (Not the name of your insurance company):_____

Primary's DOB: _____/_____/_____ Primary's SS#: _____ _____ _____- _____ _____- _____ _____ _____ _____

Primary's relationship to Patients: **SELF** **SPOUSE** **CHILD** **OTHER**

How did you hear about us?

___School ___Insurance ___Drive by

___Advertisement ___ Google search ___ other online search

___Other: _____ ___ Friend/ Family? Who can we thank? _____

Optical History:

What is your primary Vision correction? □ **Glasses** □ **Contacts** □ **Both**

Do you wear sunglasses or UV protection? □ **Yes** □ **No**

Do you plan on purchasing glasses today? □ **Yes** □ **No** □ **Yes, if recommended**

Do you want to be fitted in contact today? □ **Yes** □ **No**

If you are currently wearing contacts:

How often do you dispose of your contacts? _____ How many hours a day do you wear contacts? _____

What contact lens solution do you use? □ **BioTrue** □ **OptiFree** □ **Clear Care** □ **Generic** □ **Other**_____

How many days out of the week do you wear your contacts? _____

Do you sleep overnight in your contacts? □ **No** □ **Yes, how many days?** _____

_____ _____

Patient / Guardian signature **Date**