



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