New Patient Information Form

First Name: ______________________________ MI: ______ Last Name: ___________________________________

How do you prefer to be addressed? (nickname, Mr./Mrs., Dr., etc) ____

Marital Status: Single Married Divorced Widowed Sex: Male Female

Date of Birth: ____________________________________ Social Security # ________________________________

Mailing Address: ____ Apt: _________

City: ____ S tate: __________ Zipcode: _________________

Home Phone: ___________________ Work Phone: ____________________ Cell Phone: ______________________

Texting is ok: Yes__ No__ Email: ___________________________________ Emailing is ok: Yes__ No__

Note: We do not share your email address or phone numbers

Employment Status (please circle): Full Time Part Time Self employed Retired Student Not employed

Primary Care Physician: ____________________ Medical Ins: ____________________ Policy #: _______________

Ins Policy holder: _________________________ Vision Ins: ______________________ Policy #: _______________

Emergency Contact Name: ___________________________________ Phone: ______________________________

Hobbies: ____

Main reason for today's visit: ____

Do you currently wear contact lenses? Yes__ No__ If yes, what type of lens do you wear? ___________________

Any problems with your current glasses or contacts? ____

There are fees to evaluate and update a contact lens prescription. I understand that these fees are not covered by most insurance, vision, or managed care plans as it is not considered part of a routine eye exam. I will notify the staff if I decide not to have this service performed.

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier direct to this office with the understanding that all monies will be credited to my account of receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also authorize release of any medical information that may be required in determination of benefits. I have received a copy of Vision Source's Privacy Statement.

____ ________________

Patient's Signature Date

____ ________________

Parent/Guardian Signature (if applicable) Date

Patient File Number: __________________________