

# WELCOME TO OUR OFFICE LIFETIME EYECARE

## Patient Information

Today's Date \_\_\_\_\_  
 Mr Mrs Ms Miss (optional)  
 Last (legal name) \_\_\_\_\_  
 First (legal name) \_\_\_\_\_ M \_\_\_\_\_  
 Preferred Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex M F  
 Last 4 Digits of SSN \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 If Dependent, Account Responsible Name \_\_\_\_\_  
 \_\_\_\_\_

**VERY IMPORTANT!**

May we thank an individual for referring you to our office?  
 Name: \_\_\_\_\_

How did you find out about our office?

- Family or Current Patients
- Insurance Plan/List
- Other Doctor Recommendations
- Staff Member
- Yellow Pages
- Priority Health Medicaid
- Miscellaneous

What is the major purpose of this visit?  
 \_\_\_\_\_  
 \_\_\_\_\_

Any problems with your current contact lenses or glasses?  
 \_\_\_\_\_  
 \_\_\_\_\_

## Insurance Information

*Please note that your insurance company may not cover all your expenses and you will be responsible for the remaining balance.*

Vision Insurance \_\_\_\_\_  
 Member Name \_\_\_\_\_  
 Contract # \_\_\_\_\_  
 Member Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_  
 Member Name \_\_\_\_\_  
 Contract # \_\_\_\_\_  
 Member Birth Date \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

Do you participate in a flex spending account?  
 Yes  No

How do you plan on taking care of your account today?  
 Cash  Check  Credit Card

## Lifestyle Questions

**Do you.....(check box if your answer is yes)**

- ..work at a computer? How much? \_\_\_\_\_ hours per day
- ..think you might benefit from thinner, lighter lenses?
- ..spend time outdoors? How much? \_\_\_Hrs/week
- ..have prescription sunwear?
- ..have more than 1 pair of current Rx eyewear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a "test drive" of the latest contact lens designs
- ..have young children?
- ..have family members in need of eyecare?

I certify that I have received a copy of Lifetime Eyecare's Notice of Privacy Practices

Signature of person received by:  
 \_\_\_\_\_

Date: \_\_\_\_\_