Classic Vision Care

Welcome Back To Our Office

Thank you for choosing our practice for your eyecare needs. If you have any questions or concerns about information requested on this form, please do not hesitate to ask for assistance. We would be happy to help.

Name _____ _____ **Date of Birth** ____/____/____ **Age** _____
Last **First**

Street _____ **City** _____ **State** _____ **Zip** _____

Cell Phone ( ) _____**Work Phone ( )** _____**Home Phone ( )** _____

E-mail Address _____

Do you have vision insurance ☐ **Yes** ☐ **No** **Do you have health insurance** ☐ **Yes** ☐ **No**

If yes, insurance carrier_____ **If yes, insurance carrier**_____

Name of Insured _____ **Relationship to patient** _____

Insured's Date of Birth ____/____/____ **Social Security#**_____

Employer _____ **Work Phone ( )** _____ **ext** _____

Insurance Company _____ **Group #** _____ **ID #** _____

We will need a copy of both sides of your insurance card, as well as your driver's license.

Changes in Medical History / Medications

Problems with Present Glasses and / or Contacts

Problems with Vision – Distance and/or Near (please specify):

Diagnosis Issues

Do you have one or more pairs of current glasses?	Yes	No	N/A
Do you work on a computer for long periods of time?	Yes	No	N/A
If you wear glasses, would you benefit from thinner and lighter lenses?	Yes	No	N/A
If you wear bifocals, are you bothered by restricted areas, lines, or head-tilting?	Yes	No	N/A
Are you bothered by glare when you drive at night?	Yes	No	N/A
If you wear contacts, are you happy with your vision and /or comfort?	Yes	No	N/A
If you have not worn contacts before, would you be interested in a "test drive" of the latest in contact lens design?	Yes	No	N/A
Do you desire information regarding laser vision correction (Lasik) and/or a FREE evaluation regarding your candidacy?	Yes	No	N/A
Are you interested in information regarding "Ortho-K" , a non-enasive, non-surgical procedure that can eliminate the need for glasses/contacts during the day?	Yes	No	N/A

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