Welcome Form

Name:______________________________ Nickname: _____________ Date of Birth:______________

Today's Date: ______ Age: _______ Sex: M F *E-mail address:* ____________________________

Address: __________________________City:_______________ State: ______ Zip:______________

Home Phone: _______________________ Cell Phone: _________________________________

Employed by (or school): ______________________ Occupation: _____________ Work Phone: _____________

Patient's or primary insured's SSN (if filing insurance only): ______________________________________

Marital Status: Single _____________ Married: __________ Divorced: __________Widowed _______________

ARE YOU A PREVIOUS PATIENT OF THIS OFFICE? ☐ No ☐ Yes

When was your last eye exam anywhere? ________________ Where?: _________________________________

Please circle your method of payment for today's exam, even if this is only insurance co-pay:

Cash **Credit / Debit Card** **(sorry, we no longer accept checks)**

Insurance Do you have **VISION** insurance? ☐ No ☐ Yes If yes, Insurance company: ____________

Insured person's ID number ________________________ Vision Plan____________________

Your relationship to the insured______________

Do you have Medicare? ☐ No ☐ Yes Secondary Ins. Carrier_______________________

Do you have Medicaid? ☐ No ☐ Yes (circle one): Molina Wellcare Opticare Healthy Connections

- -

(Office use only) Authorization #____________________ Plan Code__________ Co-Pay _______

NCT: OD____________ OS:____________ CL fits covered? ☐ No ☐ Yes

***Main reason for today's visit:**____

*Has your vision gotten worse since your last exam, or **are you having trouble seeing? ☐ No ☐Yes**

If yes, is it; ______ far away ________ reading up close ________ computer

Are your eyes hurting, irritating, burning, or red on an ongoing basis? (circle which) ☐No ☐Yes

Are you interested in: ☐ Glasses ☐ Contacts ☐ Both

Have you ever worn contacts before? ☐ No ☐ Yes

Do you sleep in your contacts? ☐No ☐Yes If yes, how many nights in a row? ________________

**** How often do you replace each pair of contact lenses **** (be honest now!)? ___________________

Name of your primary physician __________________________

Please continue onto the back of this sheet and complete the form