



Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date: _____

Patient Information

Last: _____
First: _____ MI: _____
Date of Birth _____ Age _____
Street: _____
City: _____ State: _____
Zip Code: _____
Gender: Male Female
Preferred Phone (Circle one): Home Cell Work
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Employer (or School): _____
Occupation (or Grade): _____
Emergency Contact _____
Emergency Phone _____
Referred By _____

If not referred, how did you hear about our office?

- Friend or Relative Name: _____
- Another Doctor
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Website
- Online Search. If yes, where did you find us? _____

- Other: _____

Insurance Information

Vision Insurance: _____
Subscriber Name: _____
Subscriber SSN/ID#: _____
Subscriber Birth Date: _____

Primary Medical Insurance: _____
Subscriber Name: _____
Subscriber SSN/ID #: _____
Subscriber Birth Date: _____

ASSIGNMENT OF BENEFITS/ FINANCIAL RESPONSIBILITY

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Eminence Family Eyecare unless payment is made in full at time of service. I agree to bear full responsibility for co-pays, deductibles, non-covered or denied services by my insurance.

Signature: _____ Date _____

Relationship to Patient (If minor): _____

Lifestyle Questions

Do you...(check all that apply):

- ...use digital devices on a regular basis? If yes, how many hours per day? _____ hrs/day
 - ...think you might benefit from thinner, lighter lenses?
 - ...prefer NOT to wear glasses at times?
 - ...spend time outdoors? How often? _____ hrs/week
 - ...participate in vision-related sports or other activities?
- If yes, please specify: _____