

# Mission Optometry

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Employer/School \_\_\_\_\_

Occupations/Grade \_\_\_\_\_

Spouse/Parent's Name \_\_\_\_\_

Spouse/Parent's Workplace \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex: Male Female

Email Address \_\_\_\_\_

Whom should we notify in case of an emergency?

\_\_\_\_\_  
(name) (telephone) (relationship)

What is the primary purpose of this visit?

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

\_\_\_\_\_

## LIFESTYLE QUESTIONS

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

- ..work at a computer? How much? \_\_\_\_\_ Hrs/day
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in trying the latest contact lenses?
- ..spend time outdoors? How much? \_\_\_\_\_ Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical vision correction?
- ..have more than one pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

## VERY IMPORTANT!

Whom may we thank for referring you to our office?

Name of friend or relative? \_\_\_\_\_

If not referred, how did you choose our office?

- Another Dr. \_\_\_\_\_
- Insurance Company
- Saw Sign/Building
- Yellow Pages
- Web Page
- Other \_\_\_\_\_

## INSURANCE INFORMATION

Vision Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

I understand that I am responsible for any charges not covered by my medical or vision insurance:

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)