

**Patient Information**

**Date:**

*Mr. Mrs. Ms. Miss. Dr.* \_\_\_\_\_ Marital Status: *Married Single Divorced*  
Name Last Name: First MI Nickname

Address \_\_\_\_\_

Phone Home Work Cell

e-mail: SS # Date of birth:

Employment

Student: full/ part School:

**Insurance Information**

**Guarantor, Relationship** \_\_\_\_\_ *Mr. Mrs. Ms. Miss. Dr.* Marital Status: *Married Single Divorced*

Name: Last Name: First MI Nickname

Address:

Phone: Home Work Cell

e-mail: SS # Date of birth:

Employment

Student: full/ part School:

**Health / Medical Care Insurance [separate from Vision Coverage]**

**Primary**

Insurance Company ID #

Name of Insured if not guarantor/relationship: *Self*, \_\_\_\_\_

**Secondary**

Insurance Company ID #

**Vision Plan/Coverage**

**Primary**

Plan: ID #

**Secondary**

Plan: ID#

**Payment: Cash Check Credit Card \*\*\*\* All copays are due at time the services are rendered Thank You**

**Signature on File**

1. I authorize release of information to all my insurance companies
2. I authorize my insurance company to send payment directly to my doctor
3. I understand that I am responsible for my bill, and there may be charges that my insurance does not cover, and I will pay for those non-covered services.

Print Name

Signature (Parent/Guardian/Guarantor)

Print Name of Parent/Guardian/Guarantor

Date

## Lifestyle Questionnaire

Dear Patient: This questionnaire was created to assist us in helping you choose the eyewear best suited to your particular needs and lifestyle concerns. Please take a moment to answer all the questions that apply to you. Thank you for taking the time to complete the form.

1. What do you like about your current pair of glasses and or contact lenses?

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2. What don't you like about your current pair of glasses and or contact lenses?

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3. Do your home maintenance activities included: (circle all that apply)

gardening/landscaping	auto repair	soldering/welding
yardwork	use of power tools	plumbing
painting	woodworking	other

4. What are your favorite hobbies/recreational activities: (circle all that apply)

cooking	cards/bingo	painting	golf
sewing	woodworking	musical instrument	skiing/skating/snow boarding
needlepoint	fishing	art	snorkling/scuba/swim
board games	boating		

5. Are you bothered by glare from any of the following? (circle all that apply)

night driving/headlights	haze	flourscent lights
sunshine/uv exposure	computer screens	other

6. Does your work entail unusual visual demands due to any of the following: (circle all that apply)

distance viewing	outdoor work	natural or artifical lighting	caustic enviroment
near viewing	indoor work	abrupt changes in light levels	clean room
position	driving		other

7. Do you currently use more than one pair of glasses? [NO] [YES] (circle all that apply)

distance	bifocals	scuba specs	golf
reading	trifocals	swim goggles	tennis
intermediate	multifocals	ski goggles	shooting
computer	occupational	driving	hunting
hobbie _____	sunglasses	protective eyewear	

8. Do you see clearly with the glasses for all the tasks which you need to complete? YES  
NO (explain)

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9. What is potentially the most hazardous activity you participate in on a regular basis, either at work or outside the workpla

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10. Do you use a computer [NO] [YES] What is the distance from the screen to your eyes? \_\_\_\_\_  
Is the screen positioned to your Right Left Center? How many hours do you spend at the computer? \_\_\_\_\_

11. Do you currently wear contact lenses? [NO] [YES] What ype of lens? (soft/disposable/gas permeable/bifocal etc.)

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What disinfection system do you use? \_\_\_\_\_ How many hours a day do you wear your contact lenses? \_\_\_\_\_

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Please list all family members living at home:

Name

Last eye exam

Date of birth

Thank You

Revised Dr. Groo 3/05