

## WELCOME TO OUR OFFICE

Thank you for choosing Clements Vision Care! Please complete this questionnaire prior to your appointment and give it to the front desk staff when you arrive.

- Please bring your Vision Insurance and Health Insurance ID cards to your appointment.
- Contact lens patients- Wear your contact lenses to your appointment. Bring your glasses and your contact lens prescription or boxes.

We accept the following payment methods at the time of service: Cash, Check, Visa, MasterCard, Discover and CareCredit.

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

Sex:  M  F  Other Date of Birth \_\_\_\_\_

Last four digits of Social Security Number \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Employer (or School) \_\_\_\_\_

Occupation (or Grade) \_\_\_\_\_

Parent or Guardian Name(s) if under 18 \_\_\_\_\_

Family Physician / Location \_\_\_\_\_

Insurance Holder name (If Different Than Patient) \_\_\_\_\_

Insurance Holder Date of Birth \_\_\_\_\_

Please list any other family members that are patients at Clements Vision Care \_\_\_\_\_

Vision Insurance Carrier and ID Number \_\_\_\_\_

Medical Insurance Carrier and ID Number \_\_\_\_\_

Are you interested in laser vision correction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you currently wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you interested in contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	What kind?	_____	
Do you wear 100% UV Blocking Sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>	Solutions	_____	
Have you ever worn contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>			

How did you hear about Clements Vision Care? \_\_\_\_\_