Welcome to Superior Vision

Patient Information Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____

Patients Address: _____City: _____State: ___ Zip: _____

SSN: _____ Age: ____ Birth Date: _____ Sex: Male: __ Female: __

Marital Status: Single: ___ Married: ___ Divorced: ___ Widowed: ___ Other: _____

Race: _____Occupation: _____Email: _____

Would you like to receive TEXT message confirmations? Yes: ___No: ___

How did you hear about us? _____

What is the Name and Number of your Primary Care Physician? _____

Guardian: _____

Primary Insurance: Please Circle (Vision or Medical)

Subscriber's Name: _____SSN: _____ DOB: _____

Relationship to Patient: _____ Phone #: _____

Address (if different from patient):_____

City/State/Zip: _____

Insurance Company: _____ ID#:_____ Group #:_____

Secondary Insurance: Please Circle (Vision or Medical)

Subscriber's Name: _____SSN: _____ DOB: _____

Relationship to Patient: _____ Phone #: _____

Address (if different from patient):_____City/ST/Zip: _____

Insurance Company: _____ ID#:_____ Group #:_____

Questions

- What's the main reason for your visit today? Exam: ____Glasses: ____Contacts:____
- Have you ever worn? Eyeglasses_____ Contacts _____
- Have you ever had LASIK? Yes:___ No:___ If yes, when: _____
- When was your last eye exam? _____
- Do you smoke? Yes:___ No:___ How long? _____ How many packs a day? _____
- Do you have Allergies? Yes:___ No:___ Seasonal? Yes:___ No:___ Other:_____