Please fill out in INK

Patient Name______________________________Birthdate____/____/____
Mailing Address______________________________SSN_____/____/______
City______________________________State________Zip_________
Home Phone____________________ Work Phone____________________
Gender: ___F ___M Marital Status: ___single ___married
Occupation____________________ Employer____________________
Hobbies/sports______________________________
Name of Spouse or Guardian______________________________
Email address ***(always confidential, never shared***)______________________________

Please list your eyecare insurance=> MEDICARE___
OTHER: Carrier____________________ Policy #____________________
Secondary Carrier____________________ Policy #____________________

Please list your Health insurance (different from your eyecare coverage)=> MEDICARE___
OTHER: Carrier:____________________ Policy #____________________
Secondary Carrier:____________________ Policy #____________________

What is the purpose of your visit today?______________________________

1. If you currently wear eyeglasses- ***if NOT, skip to #2***

1. Do you have: a spare pair? ___no ___yes Does it have the correct prescription? ___no ___yes
   prescription sunglasses? ___no ___yes Do they have your correct prescription? ___no ___yes
2. Are there certain times when you would rather not wear eyeglasses? ___yes___no

2. Do you work at a computer? ___no ___yes Do you have computer glasses? ___no ___yes

3. Circle any you would like to discuss/update today:
Contact Lenses (Colored?) LASIK Surgery Non-Surgical alternative to LASIK (CRT)

4. If you currently wear Contact Lenses-please answer all questions-*if NOT, skip to #5*

1. Do your backup glasses have your correct prescription? __no __yes
2. What type do you wear? (***check all that apply***)
   o Soft o GasPerm o daily wear o overnight wear
   o monovision o bifocal o tinted o disposable
3. Would you like to have your Contact Lens Rx updated today? __yes __no
4. How old are your lenses?______________________________
5. How often do you replace your lenses?______________________________
6. What is your typical wearing schedule? ____hrs/day, ____days/week
7. Do you experience any of the following symptoms?
   ○ Late day dryness/irritation ○ Red eyes ○ Tired eyes ○ other____________________

5. How did you find out about our office?
Friend____________________ Doctor____________________
other- yellow pages TV Ad newspaper insurance plan

6. Method of payment Cash Check Visa/MC Vision Care Plan
Who is responsible for your bill (charges not covered by insurance)? __self other____________________

I hereby authorize:

1. Any physician, hospital or medical facility to provide all information on my medical and refractive history and treatment to Woodland Vision Source.
2. Payment directly to the doctors at Woodland Vision Source for the eyecare and/or medical/surgical benefits, if any, otherwise payable to me under the terms of my insurance.
3. Photocopies of this form to be as valid as the original.

I understand that:

1. Professional fees are due at the time services are rendered, unless arrangements are made otherwise, in advance.
2. Professional fees are non-refundable.
3. The doctors and staff at Woodland Vision Source cannot be held responsible for erroneous or incomplete information regarding my insurance coverage supplied by me or my insurance company. I am ultimately responsible for services and materials if my insurance does not pay as anticipated.
4. I can receive a discount if I pay my bill today, and my total payment may be less if I do so.

Signature______________________________Date___/___/___