

# Welcome to Our Office

*This information will allow us to begin the process that ensures your eye health and vision remain at their best, and that your health and lifestyle needs are met. Thank you for your help.*

Your Name \_\_\_\_\_  
Miss \_\_\_\_\_  
Mrs. \_\_\_\_\_  
Ms. \_\_\_\_\_  
Mr. Last First Middle Nickname/Preferred  
Dr. \_\_\_\_\_  
Rev. \_\_\_\_\_

Your Address \_\_\_\_\_

Street or P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth - - SS# - - Phone \_\_\_\_\_

home \_\_\_\_\_ work \_\_\_\_\_

E-mail address \_\_\_\_\_ cell# \_\_\_\_\_

Your employer \_\_\_\_\_ Your Family Doctor \_\_\_\_\_

If married, name of spouse \_\_\_\_\_ Spouse employed by \_\_\_\_\_

If under 18, name of parent or guardian \_\_\_\_\_ Relation \_\_\_\_\_

Phone - Employer \_\_\_\_\_

If student, grade level \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_

Why did you come to us? \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Where does the rest of your family go for eye care? \_\_\_\_\_ # in household \_\_\_\_\_

How will you be paying today? & Full payment by cash, check, or credit card & Vision Care insurance with deductible  
& Full payment for professional fees, deposit on eyeglasses, balance paid on dispensing

Vision Insurance \_\_\_\_\_  
carrier name \_\_\_\_\_

Medical Insurance \_\_\_\_\_  
carrier name \_\_\_\_\_ co-insurance/supplemental \_\_\_\_\_

Insured's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

"I request that payment of benefits be made to me or the doctor for any services provided by her. I understand that if for any reason, my insurance denies services rendered, I am responsible for paying my account in full. All special orders (glasses or contact lenses) require a deposit of at least 50%. The balance is paid in full when material is delivered. I understand that my account will be charged an interest rate of 1.5% compounded monthly on any balance 60 days or older. If the account is turned over for legal collection, the patient (parent or guardian) is also responsible for all costs of collection plus attorney and court fees."

signature \_\_\_\_\_ date \_\_\_\_\_

**Your occupation and lifestyle play the most important roles in determining your visual requirements.  
How you use your eyewear directly affects their performance.  
Tell us about your lifestyle...**

What is your occupation? \_\_\_\_\_ How Long? \_\_\_\_\_

What hobbies or activities do you enjoy? \_\_\_\_\_

What special vision needs do you have? (computer, overhead work, etc.) \_\_\_\_\_

**Acknowledgement Of Receipt**  
I acknowledge that I received a copy of Nina J. Cox, O.D.'s Notice of Privacy Practices.  
Date \_\_\_\_\_ Patient Name \_\_\_\_\_  
Signature \_\_\_\_\_  
(if under 18, parent's signature)

**Thank You.**  
(form continued on back)

How long has it been since your prescription was changed?

\_\_\_\_\_ Glasses \_\_\_\_\_ Contact Lenses

Are you having any specific problems with your eyes? \_\_\_ YES \_\_\_ NO

If YES, please explain \_\_\_\_\_

Please check any of the following PERSONAL HEALTH and EYE HISTORY conditions that apply to you: PAST or PRESENT

\_\_\_ Allergies \_\_\_ Drug Sensitivities \_\_\_ Glaucoma \_\_\_ Cataracts \_\_\_ Eye Diseases \_\_\_ Asthma \_\_\_ Diabetes

\_\_\_ Lazy Eye \_\_\_ Blindness \_\_\_ Eye Surgery \_\_\_ Thyroid \_\_\_ Hay Fever \_\_\_ Pregnant \_\_\_ Eye Injury

\_\_\_ Heart Condition \_\_\_ High Blood Pressure \_\_\_ Headaches = When do you get them? \_\_\_\_\_

Are you presently taking any hormones including birth control pills? \_\_\_ YES \_\_\_ NO

Please LIST all the MEDICATIONS you are currently taking \_\_\_\_\_

Please check any of the following FAMILY HEALTH HISTORY conditions that apply to your blood relatives (i.e Father, Mother, Brother, Sister)

\_\_\_ Diabetes \_\_\_ Glaucoma \_\_\_ Cataracts \_\_\_ Blindness \_\_\_ Eye Diseases \_\_\_ Heart Disease

\_\_\_ Tuberculosis \_\_\_ High Blood Pressure \_\_\_ Thyroid

Do you CURRENTLY wear: \_\_\_ GLASSES \_\_\_ CONTACT LENSES

If you have stopped wearing your contacts, why did you quit? \_\_\_\_\_

Are you interested in wearing contact lenses now? \_\_\_ YES \_\_\_ NO

When do you wear your GLASSES? \_\_\_ All the Time \_\_\_ Reading and Near Work \_\_\_ Distance Only

\_\_\_ Computer Work \_\_\_ Work Safety \_\_\_ Nights or Weekends Only

What type of CONTACT LENSES do you wear? \_\_\_ Soft \_\_\_ Gas Permeable \_\_\_ Tinted \_\_\_ Bifocal

\_\_\_ Extended Wear \_\_\_ Disposable \_\_\_ Not Sure

WE DO NOT BILL OUR ACCOUNTS!

Please indicate your method of payment:

\_\_\_ Check \_\_\_ Credit Card \_\_\_ Cash

YOU WILL NEED TO PLACE A DEPOSIT ON CONTACT LENSES OR PAY IN FULL BEFORE THEY ARE ORDERED.