WELCOME

Thank you for choosing Northville Vision Clinic for your eyecare needs. Please complete this form. If you have any questions or concerns, please ask for assistance, or call 248-348-1330. We will be happy to help you.

PLEASE BRING YOUR GLASSES AND/OR CONTACT LENS BOXES

Today's Date: _____

Patient's Name:	_____	( ) Male	( ) Female
Birthdate:	____-____-_____	Patient's Social Security #:	_____-____-_____
Street Address:	_____	Email Address:	_____
City:	_____, MI	Zip:	_____
Phone #:	_____	( ) Home ( ) Cell	( ) Work
Phone #:	_____	( ) Home ( ) Cell	( ) Work

Occupation: _____ Employed by: _____

Name of spouse, if any: _____

Names of children, if any: _____

Whom may we thank for referring you to us? _____

VISION INSURANCE INFORMATION	
Patient's Vision Insurance Company:	
Is Patient the policy holder?	( ) Yes ( ) No
If Yes: ID# if different than Social Security #:	
If No: Name of policy holder:	
Policy holder's birthdate:	
Policy holder's ID# or Social Security #:	

MEDICAL INSURANCE INFORMATION	
Patient's Medical Insurance Company:	

Last optical exam: _____ Year(s) ago

Do you wear glasses? ( ) Yes ( ) No

When do you wear glasses? ( ) All The Time ( ) Computer Work ( ) Other

( ) Reading/Close Work ( ) Distance

Have you ever worn contact lenses? ( ) Yes ( ) No

If Yes, what type of contact lenses do you wear? _____

If No, are you interested in wearing contact lenses? ( ) Yes( ) No

What hobbies do you participate in?_____

Are you interested in laser surgery to correct your vision? ( ) Yes ( ) No

I am aware that the HIPAA privacy statement is posted in the office for my review and that copies are available upon request:

Signed_____