

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:	_____		
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 _____