Welcome

Lifetime Vision Center

Name_____ **Address**_____

City_____ **State**_____ **Zip**_____

Patient's Date of Birth: ____/____/____ **Patient's Social Security**_____

Email: _____

Employer_____ **Occupation**_____

Preferred Phone_____ (Circle one) **Home** **Work** **Cell**

Emergency Contact_____

Preferred Language: (Circle one) English Spanish

Patient's Medical Insurance Company: _____

Insurance Member ID: _____

Patient's Vision Insurance Company: _____

Primary Insurance Carrier: _____

(if different than above)

Please fill out If patient is a minor

Parent's Date of Birth: ____/____/____ **Parent's Social Security** _____

Emergency Contact /Guardian / POA

Name_____

Address_____ **Phone**_____

Relationship to Patient: _____

Who may we thank for referring you to our office? _____

Hobbies/ Activities/ Interests_____

Date of last eye exam: _____ **By whom:** _____

What type of lenses do you wear now? (Circle One) Single Vision Bifocal Trifocal Progressive (no line)

Are you a current Contact Lens wearer? If not, are you interested in Contacts? (Circle One) Yes No