CLEARFINITY EYECARE
OPTOMETRIST
— VISION FOR LIFE. A CLEAR CHOICE. —

Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date: _____

Patient Information

Last: _____

First: _____MI: _____

Street: _____

City: _____State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

How do you prefer to be contacted?

(Indicate #1 and #2 preference):

Home #___Work #___Cell #___Text___Email____

Patient's SSN: _____

Date of Birth: _____Age: _____

Sex: M F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____

Spouse (or Parent's Work): _____

If not referred, how did you choose our office?

☐ Friend or Relative Name:_____
☐ Another Doctor
☐ Insurance List
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Website

☐ Online Search. If yes, where did you find us? _____

_____

☐ Other: _____

Insurance Information

Vision Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID#:_____

Subscriber Birth Date:_____

Primary Medical Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID #:_____

Subscriber Birth Date:_____

Secondary Medical Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID#:_____

Subscriber Birth Date:_____

Do you participate in a flex spending account?

☐ Yes ☐ No

Lifestyle Questions

Do you…(check all that apply):

☐ …use digital devices on a regular basis? If yes, how many hours per day? _____hrs/day
☐ …think you might benefit from thinner, lighter lenses?
☐ …prefer NOT to wear glasses at times?
☐ …spend time outdoors? How often? ____hrs/week
☐ …participate in vision-related sports or other activities?

If yes, please specify:_____

_____

CONTACTS LENS INFO

Currently Wear Contacts/Interested in Contacts? (Circle)
Type and Brand of Contacts_____
Cleaning Solution