

# ENVISION BOULDER

## WELCOME TO OUR OFFICE

DATE: \_\_\_\_\_ Appointment is with: Dr. Smith \_\_\_\_ Dr. Graham \_\_\_\_ Dr. Israelson \_\_\_\_

### PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Person Responsible for Payment (if other than patient):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

### INSURANCE INFORMATION: (please check any that apply)

Vision Insurance: Vision Service Plan (VSP) \_\_\_\_ Superior Vision \_\_\_\_ Aetna \_\_\_\_ Humana \_\_\_\_

Name of Primary Insured (if other than patient): \_\_\_\_\_ Relation: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Medical Insurance: Medicare \_\_\_\_ Aetna \_\_\_\_ Anthem \_\_\_\_ Blue Cross Blue Shield \_\_\_\_ Cigna \_\_\_\_

UnitedHealthcare \_\_\_\_ Other \_\_\_\_\_

**NOTE: Payment is expected at the time services are rendered, including co-payments and insurance overages. Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. Please understand that financial responsibility for your account is yours and not that of your insurance company.**

### PERSONAL EYE INFORMATION:

Do you wear glasses? Y/N Do you wear contact lenses? Y/N Type: \_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_ Date of Last Eye Exam: \_\_\_\_\_

### MAIN REASON FOR TODAY'S VISIT: (please check all that apply)

Routine \_\_\_\_ Update Glasses \_\_\_\_ Update Contact Lenses \_\_\_\_ Laser Vision Consult \_\_\_\_

New Contact Lens Fitting \_\_\_\_ Eye Problem \_\_\_\_\_

Are you experiencing any of the following?: (please check all that apply)

Blurred distance vision \_\_\_\_ Blurred near vision \_\_\_\_ Both \_\_\_\_ Poor night vision \_\_\_\_

Floaters \_\_\_\_ Flashes of light \_\_\_\_ Double vision \_\_\_\_ Headaches \_\_\_\_ Eye pain \_\_\_\_

Computer eyestrain/headaches \_\_\_\_ How many hours per day do you work on a computer? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Relative \_\_\_\_ Friend \_\_\_\_ Co-worker \_\_\_\_ Insurance List \_\_\_\_ Yellow Pages \_\_\_\_

Location \_\_\_\_ Internet \_\_\_\_ Another Doctor \_\_\_\_ Other \_\_\_\_\_

O: \_\_\_\_\_ Tech: \_\_\_\_\_