

# Karns Vision Center

Welcome to our office! It is our pleasure to serve you!!

Date \_\_\_/\_\_\_/\_\_\_

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

Address: \_\_\_\_\_ Zip Code \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Marital status (circle): Single Mar Div Wid Sex: Male Female

Home Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Preferred contact: Cell Home Work Email May we send you texts for reminders/notifications? Y N

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email address \_\_\_\_\_ @ \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Retired? Yes No

How long ago was your last eye exam? 1 year 2 years longer Were your eyes dilated? Yes No

Do you get regular physical examinations from your primary care doctor? Yes No

Name of primary care doctor \_\_\_\_\_

For children under 18: Names of parents: \_\_\_\_\_

How did you hear about our office? (Please circle)

Friend or family (name) \_\_\_\_\_

Insurance Company

TV commercial

Family Doctor Mailing Received

Location/drive by

Karns Shopper Ad

Ophthalmologist Internet [www.karnsvision.com](http://www.karnsvision.com)

Radio (station) \_\_\_\_\_

Billboard

**\*\* It is your responsibility to provide us with your vision or medical insurance information BEFORE services are rendered. We cannot be responsible for retrieving your private insurance information (including available benefits and copayments) without your consent and direction.**

Vision Insurance \_\_\_\_\_

Insured's name \_\_\_\_\_

Medical Insurance \_\_\_\_\_

Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Secondary Medical \_\_\_\_\_

Insured's Date of birth \_\_\_/\_\_\_/\_\_\_

**Eyeglass History**

Do you currently wear glasses? Yes No Full time Distance only Near only Computer

Do you use a computer frequently? Yes No

Do you have problems with night vision? Yes No

**Contact Lens History**

Do you currently wear contacts? Yes No Would you like to be fit with contacts today? Yes No

Have you ever tried to wear contacts before? Yes No

Do you have glasses with your current prescription? Yes No

What type or brand of contact lenses do you wear now? \_\_\_\_\_

Do you sleep in your contact lenses? Yes No

What brand of solutions do you use? Opti-Free ReNu Clear Care Complete Boston Store brand