Green Valley Optometry

Dr. Sylvia Lee **Dr. Corwyn Mosiman**

DATE _________________________

Last name First Middle I. Male Female

Social security# Date of Birth

Home # Cell # E-mail

Address City Zip

If patient is a minor, who is responsible for the bill? Name SS#

Occupation Employer Work # Ext

Business Address City Zip

Spouse's name Date of Birth Employer

Whom may we contact in case of emergency? Name Phone #

How did you hear about our office?

All balances are due and payable at the time of service including co-pays and deductibles. Signature Date

Lifestyle Vision Needs

Please let us know about the various activities in which you participate and how we can assist in choosing the eyewear that is just right for you.

Daily Activities	Tell us about your vision and vision requirements.
☐ Reading hours/day ________ ☐ Computer use hours/day_______ ☐ Driving daytime ☐ Driving nighttime ☐ Outdoors in the sun hours/day ______ ☐ Work outdoors in dusty areas ☐ Other ____________________________ ☐ Play sports – types _________________ ☐ Hobbies _______________________________	☐ What part of your vision bothers you the most? Distance Computer Reading All ☐ Glare from the computer, overhead lights or nighttime lights bother me. ☐ My eyes feel very sensitive to sunlight or bright lights. ☐ My eyes sometimes feel gritty and irritated. ☐ I am interested in contacts or laser vision correction as an alternative to wearing my glasses.
What do you like about your current glasses or contacts (style, comfort, durability/flexibility of frame,etc)?.________________________________	What don't you like about your current glasses or contacts (weight, thickness, glare, etc)? _____________________________ ____

For office use only

Copy of insurance card taken? Primary ☐Medical ☐Vision VSP MES Eyemed Spectera

Secondary ☐Medical ☐Vision VSP MES Eyemed Spectera