Welcome to Silver Creek Optical

Patient Information: Glasses/Contacts

Name: _____ **Date:** _____

Address: _____ **City:** _____ **Zip:** _____

Birth Date: _____ **Age:** ____ **Home Phone#:** _____ **Work Phone**

Employer: _____ **Address:** _____

Email: _____

INSURANCE INFORMATION:

Name Of Insurance: _____

ID# _____

Acknowledgment Of Receipt Of Notice Of Privacy Policies

You may refuse to sign this acknowledgment.
I have received a copy or viewed a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

We wish to inform you that we may use your personal health information to complete treatment, payment or health care options. Please refer back to the Notice of Privacy Practice for descriptions of any uses and disclosures. You have the right to revoke the consent in writing, except for action already in compliance with the consent.

Patient Questionnaire

Patient Name: _____ **Date:** _____

Thank you for entrusting the health of your eyes to us. Our commitment is to provide you with highest standards of care in an open, honest environment. To help us serve you the best, please answer the question below so we can learn more about your vision and how you use your glasses. Our highly trained staff will use this information to provide a vision solution that meets your needs.

Do you wear your glasses all day?	NO	YES
Do you experience difficulty with nighttime vision, like glare when driving at night?	NO	YES
Are you constantly going in and out of sunlight throughout the day?	NO	YES
How many hours per day do you spend on the computer or with hobbies that require close vision? ____HRS		
Do you need bifocal correction, but dislike having a bifocal line on you lenses?	NO	YES