Acadian Vision Associates

For a Lifetime of Healthy Vision

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W. Donner Mizelle O.D. Leanne C. Gilder O.D.

WELCOME TO OUR OFFICE

Patient Registration

Name: _____ Email: _____ Sex: M F

Mr. Mrs. Ms. Dr. _____ Date of Birth: ___/___/___ SS#: _____

Account Responsible (If minor child): _____ D.O.B_____

Patient Address: _____

Street City State Zip

Home Phone: _____Cell Phone: _____ Work: _____

Insurance Name_____ Policy #_____

Policyholder's Name_____ Policyholder's D.O.B._____

Employer (or School): _____ Occupation (or grade): _____

Family Members who are Patients: _____

Hobbies: _____

Do you wear: Glasses Contact Lens Both (Please circle one)

If Contact Lenses, what kind? _____ Solutions used: _____

Average # of hours worn daily: _____ Average # of days sleeping in lenses? _____

# of hours worn today: _____ Or last worn: _____

Are you interested in contact lenses? Yes No

What kind? Soft Gas Permeable Extended Wear Tinted Disposable BiFocal

Are you having any problems with your current glasses or contact lenses? Please explain:

_____

_____

_____

Do you use a computer or VDT at work or at home? Yes No

What type of office lighting do you have? Incandescent or Fluorescent

Please indicate the method of payment you will use for today's services:

_____ Cash _____ Check _____ Credit Card _____ Insurance

Preferred Communication: Email / Text / Phone / No Preference

I agree to allow Solution Reach to use the information in providing my services with Acadian Vision Associates.

Signature_____ **Date**_____