Welcome to Bella Optical

Patient Information		
Name:	Date of Birth:	
Address:		
City:	State:	Zip:
Occupation:	Employer:	
Home Phone:	Work Phone:	
Email:		

Insurance Information			
Primary Insurance Company:			
Insurance ID #:	Group #:		
Subscriber Name:	Date of Birth:		
Subscriber SSN:			
Relationship to Subscriber: (Please circle one)	Self	Spouse	Dependent Child

Referred by : (Please circle one)	Friend/Relative	Doctor	Internet	Facebook	Other
Name of Friend/Relative/Doctor:					

Patient Visual History

Do you have any hobbies?_____

Do you work at a computer terminal? YES NO Hours per day?_____

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Do you currently wear glasses? YES NO Since?_____

Type of glasses FULL TIME PART TIME DISTANCE ONLY NEAR ONLY

Glasses Owned

SINGLE VISION	BIFOCALS	TRIFOCALS
BACK-UP GLASSES	SAFETY GLASSES	PROGRESSIVES
SPORTS GLASSES	SUNGLASSES	READING GLASSES

Do you currently wear contact lenses? YES NO Brand:_____

If not, are you interested in trying contact lenses? YES NO

Are you having any problems with your present eyeglasses or contact lenses?_____

If so, please describe:_____