

**Welcome Back!**

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date: \_\_\_\_\_

**Patient Information**

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Lifestyle Questions**

**Do you...(check all that apply):**

- ...use digital devices on a regular basis? If yes, how many hours per day? \_\_\_\_\_hrs/day
- ...think you might benefit from thinner, lighter lenses?
- ...prefer NOT to wear glasses at times?
- ...spend time outdoors? How often? \_\_\_\_\_hrs/week
- ...participate in vision-related sports or other activities? Specify:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**iWellness**

It is important to have an iWellness exam each year to keep up with the health and future of your eyes and vision. This is especially recommended if there is a family history of hypertension, diabetes, glaucoma, or macular degeneration. (Please see last page)



iWellness (office use only)

Yes  No

**Assignment of Benefits**

I understand that I am responsible for all charges for services provided by Nipomo Optometry. I authorize release of any medical information necessary to process my insurance claims and request payment of any benefits due to be paid directly to Nipomo Optometry.

I also understand and agree that if any services provided are not covered by Medicare and/or my private insurance carrier, I will be financially responsible for those fees.

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Date