Welcome to the office of Dr. Dominick A. Marino

The information in this confidential case history form is critical to the evaluation of your vision and health.

Lifestyle Questions:

Do you…(Check box if your answer is YES)

□..work at a computer? Y or N   How many hours? ___
□..think you might benefit from thinner, lighter glasses?
□..have problems with glare or reflection particularly when night driving?
□..spend time outdoors? How much? _______ Hrs/week
□..have interest in contact lenses?
□..have prescription sun wear?
□..find your eyes to be sensitive to the sun?
□..prefer not to wear your glasses at times?
□..want information on Laser Vision Correction surgery?
□..have more than 1 pair of current Rx eyewear?
□..have children? If so, are they having problems in school? Y or N
□..have family members in need of eye care? Y or N
□..plan on getting new glasses today? Yes / No / Only if Rx changes

What is the major purpose of this visit? ________________________________
____
Any problems with your current contact lenses or glasses?________________
____

Email ____

Insurance Information:

Please note that some insurance may NOT cover the Refraction or the Contact Lens Follow-Up Evaluation

Vision Insurance ______________________________________
Subscriber Name ______________________________________
Subscriber ID Number __________________________________
Subscriber Birth Date __________________________________

Primary Medical Insurance______________________________
Subscriber Name ______________________________________
Subscriber ID Number __________________________________
Subscriber Birth Date __________________________________
Relationship to Insured: ________________________________

** **Please provide a current DL or ID and Insurance Card** **