VISION CARE

PATIENT INFO

Patient Name ______________________
Address ______________________
City | State | Zip ______________________
SSN ______________________
Email ______________________
Parent's Name (if minor) ______________________
O Single O Married O Life Partner
Preferred Language ______________________

Date of Birth ______________________
Home Phone ______________________
Work Phone ______________________
Cell Phone ______________________
Employer ______________________
Occupation ______________________
O Full Time O Part Time O Full Time Student
Race ______________________
Ethnicity ______________________

INSURANCE

Insurance Co. #1 ______________ O Vision O Medical
Subscriber ______________________
Date of Birth ______________________

Contact # ______________________
O HMO O PPO O Traditional
Group # ______________________

Insurance Co. #2 ______________ O Vision O Medical
Subscriber ______________________
Date of Birth ______________________

Contact # ______________________
O HMO O PPO O Traditional
Group # ______________________

Primary Care Physician ______________________
Address ______________________

Phone ______________________
Hobbies, Special Vision Needs ______________________

CURRENT VISION INFO

I Wear Glasses .... O Yes O No
I've Had Laser Corrective Surgery .... O Yes O No
Interested in LASIK? .... O Yes O No
I Wear Contacts.................................... O Yes O No
Type of Contacts ______________________
I Replace My Contacts Every ______________________
Date of Last Eye Exam ______________________

Name of Previous Eye Doctor ______________________
Referred by:
O Doctor O Friend O Family O Insurance O Ad

SIGNATURE

Due to the Health Insurance Portability and Accountability Act, your initials and signature are required below:

Initials:

__________ I *authorize* any holder of my medical information about me to release to my insurance company or its agent any information needed to determine these benefits payable or related services. I request that payment of authorized services be made on my behalf to Vision Care. I agree to be personally and fully responsible for co-pays, deductibles, non-covered and denied services by my insurance company.

OR

__________ I *decline* the above information release and am solely responsible for fees. I understand that fees are due at time of service.

__________ I *authorize* any holder of medical information about me to release and/or request my medical information with other healthcare professionals for the purpose of consultation and referral as appropriate for my healthcare.

__________ I have been provided the Vision Care Privacy Policy (You may request a copy for your records)

Signature ______________________ Relationship to Patient ______________________ Date ______________

MORE ON BACK ☞

VISION — CARE

Patient Name ______________________ Date ______________________

GENERAL HEALTH INFO

Please list any medications:

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Please list any allergies (medical and general):

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Do any of the following conditions apply to you?

- O Constitutional Fever (Fever, Weight Change)
- O Stomach or Gastrointestinal
- O Asthma
- O Heart Condition/Disease
- O Psychological
- O Multiple Sclerosis
- O Cancer
- O Ear/Nose/Mouth/Throat
- O Kidney or Liver
- O Diabetes
- O High Blood Pressure
- O Blood Disorder
- O Arthritis or Joint
- O Immune Deficiency
- O Skin Condition
- O Lung or Respiratory
- O Stroke
- O High Cholesterol
- O Thyroid
- O Pregnant
- O Headaches
- O Lazy Eye or Eye Turn
- O Macular Degeneration
- O Retinal Detachment
- O Cataracts
- O Glaucoma
- O Dry Eye

Tobacco.................................. O Light O Moderate O Heavy

Alcohol .... O Light O Moderate O Heavy

Drug Use .... O Light O Moderate O Heavy

Height ______________________ Weight ______________________

If you indicated any of the above conditions apply to you, please explain and list treatment:

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Please list any other health conditions:

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Does your family history include any of the following? If yes, what is the relationship to you?

- O Glaucoma ______________________
- O Cataracts ______________________
- O Macular Degeneration ______________________
- O Retinal Detachment ______________________
- O Blindness ______________________
- O High Blood Pressure ______________________
- O Diabetes ______________________
- O Heart ______________________
- O Thyroid Condition ______________________
- O Other ______________________

Signature ______________________ Date ______________________

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