



WELCOME TO OUR OFFICE

Today's Date _____ / _____ / _____

PATIENT INFORMATION					
Last Name:	First Name:	MI:	Date of Birth:	Age:	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married
HOME ADDRESS:		CITY:	ST:	ZIP:	
HOME PHONE:		WORK PHONE:	CELL PHONE:		
EMPLOYER (SCHOOL)	OCCUPATION (GRADE)	EMAIL ADDRESS:			
HOW DID YOU HEAR ABOUT OUR OFFICE					
<input type="checkbox"/> INSURANCE <input type="checkbox"/> PHONE BOOK <input type="checkbox"/> Doctor Referral <input type="checkbox"/> LOCATION <input type="checkbox"/> FAMILY / FRIEND		WHOM MAY WE THANK FOR REFERRING YOU?			
IF PATIENT IS UNDER 18 YEARS OF AGE					
NAME OF PARENT / GUARDIAN	HOME PHONE	CELL PHONE	RELATIONSHIP		
May we please contact you by email? <input type="checkbox"/> Yes <input type="checkbox"/> No May we please contact you by text message? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Medical Insurance					
Name of Medical Insurance Co.	Policy Holder Name	Policy Holder Birth Date	Last 4 S/S digits and/or Employee I.D.		
Routine Vision Insurance					
Name of Routine Vision Ins:	Policy Holder Name:	Policy Holder Birth Date:	Last 4 S/S digits and/or Employee I.D.		
<h2>Insurance Authorization</h2> <p>I authorize any holder of medical or other information about me to release to the S/S administration or any other carriers of any information needed for this or a related claim. I permit a copy of the authorization to be used in place of the original and request payment of insurance benefits to myself or to the party who accepts assignment bellow. I understand that I am responsible for any cost in excess of the benefits payable by my insurance plan. I understand that I will pay for all court costs, all collection fees and or attorney's fees if my account is turned over for collection.</p> <p>Patient or Parent/Guardian Signature: _____ Date: _____</p>					

Vision Insurance is mainly designed to determine a prescription for glasses and/or contact lenses and perform a ocular health examination to look for unknown eye diseases in a presumably healthy eye. It does not cover the diagnosis and treatment of any type of eye disease or cover the evaluation of ocular manifestations of systemic diseases like diabetes or hypertension.

Medical Insurance is used when a medical condition is present that can affect the health of your eyes (i.e. high blood pressure, diabetes, glaucoma, pink eye, watery eyes, itchy eyes, etc.). If the doctor identifies the presence of disease or you need a problem addressed during your well vision visit, your insurance may require that we reschedule the well vision exam for a different appointment time. **Please give your medical insurance card to the receptionist upon completion of this history form.**

VISION CARE
ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires Vision Care, make the effort to inform you of your rights related to your personal health information. By signing bellow, I acknowledge that:

- I have read or had explained to me** Vision Care’s Notice of Privacy Practices and agree to continue my care with Vision Care under said terms.

- I was given the opportunity to read** Vision Care’s Notice of Privacy Practices and declined but wish to continue my care with Vision Care under the terms of Vision Care’s Privacy Policies.

- I have read or had explained to me Vision Care’s Notice of Privacy Practice and do not wish to continue my care with Vision Care under said terms.

- The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as:

I have read and understand this form. I am signing it voluntarily.

Patient

Date

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative Relationship to Patient

Date

ROUTINE EYE/VISION EXAM: Please check all that apply	I am interested in
<input type="checkbox"/> Need new Glasses <input type="checkbox"/> New Glasses if my prescription changes <input type="checkbox"/> Contact Lenses (New Wearer) <input type="checkbox"/> Contact Lenses (Previous Wearer) Brand: _____ <input type="checkbox"/> Routine Eye Exam	<input type="checkbox"/> LASIK/ Refractive Surgery <input type="checkbox"/> Vision Therapy <input type="checkbox"/> Longer Eye Lashes <input type="checkbox"/> Sports Vision Therapy <input type="checkbox"/> Computer Glasses <input type="checkbox"/> Polarized Sun Glasses <input type="checkbox"/> Color Contact Lenses

FAMILY HISTORY: Please note any family member with the following:	
<input type="checkbox"/> GLAUCOMA _____ <input type="checkbox"/> MACULAR DEGENERATION _____ <input type="checkbox"/> BLINDNESS _____	<input type="checkbox"/> CATARACTS _____ <input type="checkbox"/> RETINAL DETACHMENT _____ <input type="checkbox"/> DIABETES _____

PERSONAL EYE HISTORY: Please check if you currently have any of the following:
<input type="checkbox"/> BLURRED VISION <input type="checkbox"/> CATARACTS <input type="checkbox"/> BURNING EYES <input type="checkbox"/> LASIK/ PRK/ RK SURGERY <input type="checkbox"/> SANDY/GRITTY EYES <input type="checkbox"/> RED EYE (S) <input type="checkbox"/> DOUBLE VISION <input type="checkbox"/> RETINAL SURGERY <input type="checkbox"/> DROOPING EYELID <input type="checkbox"/> EYE TRAUMA <input type="checkbox"/> DRY EYES <input type="checkbox"/> EYE MUSCLE SURGERY <input type="checkbox"/> EXCESSIVE TEARING <input type="checkbox"/> EYE PAIN/ SORENESS <input type="checkbox"/> FLASHES OF LIGHT <input type="checkbox"/> FLOATERS <input type="checkbox"/> GLARE / HALOS <input type="checkbox"/> EYE/ EYELID INFECTION <input type="checkbox"/> ITCHING EYES <input type="checkbox"/> LOSS OF SIDE VISION <input type="checkbox"/> SUDDEN VISION LOSS/ <input type="checkbox"/> MUCOUS DISCHARGE <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> KERATOCONUS <input type="checkbox"/> MACULAR DEGENERATION <input type="checkbox"/> RETINITIS PIGMENTOSA <input type="checkbox"/> OTHER _____

REVIEW OF SYSTEMS: Please check if you currently have or have had any of the following :																																																																																																																																																																																																
<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:45%;"></th> <th style="width:10%; text-align: center;">Yes</th> <th style="width:10%; text-align: center;">No</th> <th style="width:10%; text-align: center;">Unknown</th> <th style="width:45%;"></th> <th style="width:10%; text-align: center;">Yes</th> <th style="width:10%; text-align: center;">No</th> <th style="width:10%; text-align: center;">Unknown</th> </tr> </thead> <tbody> <tr> <td>INTEGUMENTARY</td> <td></td><td></td><td></td> <td>GASTROINTESTINAL</td> <td></td><td></td><td></td> </tr> <tr> <td>SKIN CANCER <input type="checkbox"/></td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td>STOMACH ULCERS <input type="checkbox"/></td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td>ACNE ROSACEA <input type="checkbox"/></td> <td><input type="checkbox"/></td><td><input 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LIST OF CURRENT MEDICATIONS	MEDICAL ALLERGIES
1. _____ 2. _____ 3. _____ 4. _____ <input type="checkbox"/> I TAKE NO MEDICATIONS	1. _____ 2. _____ 3. _____ <input type="checkbox"/> NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY
TOBACCO USE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, TYPE / AMOUNT/ HOW LONG _____ ALCOHOL USE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, TYPE / AMOUNT/ HOW LONG _____ ILLEGAL DRUGS <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, TYPE/ AMOUNT/ HOW LONG _____