PATIENT FORM

Date_____

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone (Home)

Phone (Cell)

Email (please print clearly)

Preferred Contact Method *cell phone / email / text / other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time / part-time*

Marital Status *married / single / divorced / legally separated / widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance policy# / Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Relationship to Patient *self / spouse / child / domestic partner / other*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy# / Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Relationship to Patient *self / spouse / child / domestic partner / other*

Patient / Guardian Signature_____ Date_____

HIPAA

The HIPAA policy can be viewed at the front desk or a copy will be given upon request.
Please choose one of the following:

( ) I have read the HIPAA policy and agree with the statement.
( ) I have requested a copy of the HIPAA policy and have been given one, but have not yet read it.
( ) I refuse to read and/or refused a copy of the HIPAA policy and decline treatment.

I understand the HIPAA rights and agree with the guidelines. (Initials)_____

See reverse side for medical portion

PATIENT FORM *Medical Portion*

EYE HISTORY

Date of Last Eye Exam

Reason for Today's Visit

Currently Wear Glasses?

Currently Wear Contacts?

Hours Spent Reading?

Hours Spent on Computer? __Laptop __Tablet __Games

Hours Spent Outdoors?

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing / Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Vision Loss
- ☐ Lazy Eye
- ☐ Twitching

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*self*	*y*	*n*	*family*	*y*	*n*
Crossed Eyes	*self*	*y*	*n*	*family*	*y*	*n*
Glaucoma	*self*	*y*	*n*	*family*	*y*	*n*
LASIK / Corrective Surgery	*self*	*y*	*n*	*family*	*y*	*n*
Drooping Eye lids	*self*	*y*	*n*	*family*	*y*	*n*
Macular Degeneration	*self*	*y*	*n*	*family*	*y*	*n*
Retinal Detachment	*self*	*y*	*n*	*family*	*y*	*n*

PHARMACY

Name _____

Address_____

Phone_____

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS / HIV	*self*	*y*	*n*	*family*	*y*	*n*
Allergies	*self*	*y*	*n*	*family*	*y*	*n*
Arthritis	*self*	*y*	*n*	*family*	*y*	*n*
Asthma	*self*	*y*	*n*	*family*	*y*	*n*
Blood /Lymph Disorder	*self*	*y*	*n*	*family*	*y*	*n*
Cancer	*self*	*y*	*n*	*family*	*y*	*n*
Diabetes	*self*	*y*	*n*	*family*	*y*	*n*
Ears, Nose, Throat Conditions	*self*	*y*	*n*	*family*	*y*	*n*
Gastrointestinal Conditions	*self*	*y*	*n*	*family*	*y*	*n*
Heart Disease	*self*	*y*	*n*	*family*	*y*	*n*
High Blood Pressure	*self*	*y*	*n*	*family*	*y*	*n*
High Cholesterol	*self*	*y*	*n*	*family*	*y*	*n*
Kidney Disease	*self*	*y*	*n*	*family*	*y*	*n*
Lupus	*self*	*y*	*n*	*family*	*y*	*n*
Multiple Sclerosis	*self*	*y*	*n*	*family*	*y*	*n*
Neurological Conditions	*self*	*y*	*n*	*family*	*y*	*n*
Psychiatric Disorder	*self*	*y*	*n*	*family*	*y*	*n*
Seizures	*self*	*y*	*n*	*family*	*y*	*n*
Skin Conditions	*self*	*y*	*n*	*family*	*y*	*n*
Stroke	*self*	*y*	*n*	*family*	*y*	*n*
Thyroid Dysfunction	*self*	*y*	*n*	*family*	*y*	*n*
Other	*self*	*y*	*n*	*family*	*y*	*n*
Other	*self*	*y*	*n*	*family*	*y*	*n*

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked ?

PRIMARY CARE PHYSICIAN

Doctor_____

Address_____

Phone_____

FINACIAL RESPONSIBILTY & PAYMENT: The patient (or patient's guardian, if a minor) is responsible for the payment of their treatment and care. We are pleased to assist you by billing your medical insurance and vision benefits, however, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information is not correct or updated. Patients are responsible for the payments of co-pays, co-insurance, deductibles, and all other procedures or treatments not covered by their medical insurance or vision benefit plan. Full payment is due at the time of service, and for your convenience, we accept cash, Care Credit, and most major credit cards. **X**_____