PATIENT INFORMATION

☐ Mr. ☐ Mrs. _☐ Ms. _ ☐ Dr.

Name: ___________________________________ Today's Date: ______________________________

Address: _________________________________ Home Phone: _______________________________

____ Work Phone: _______________________________

Email: ___________________________________ Cell Phone: ________________________________

Date of Birth: _____________________________ SSN: _____________________________________

Employer / School: _________________________ Occupation / Grade: _________________________

INSURANCE CARRIERS

Vision Insurance: __________________________ Medical Insurance: __________________________

PERSONAL HISTORY

	YES	NO	
Are you pregnant or nursing?	☐	☐	
Do you wear eyeglasses?	☐	☐	If yes, how old is your present pair? __________
Do you wear contact lenses?	☐	☐	If yes, what type? Soft Rigid Disposable
Are you sensitive to:			
sunlight?	☐	☐	
car headlights?	☐	☐	
snow glare?	☐	☐	
Do you work outdoors?	☐	☐	If yes, how many hours per week? _____________

What activities do you enjoy routinely? (please circle)

Boating	Football	Reading
Fishing	Racquetball	Snow skiing
Hunting	Sewing	Biking
Golf	Gardening	Computer use
Baseball	Woodworking	Other: ____________________________

How did you hear about Vision Associates?

☐ Referred by family or friend: ____

☐ Referred by physician: ____

☐ Other: ____

FINANCIAL POLICY

You are responsible for services not covered by your insurance company. Any balance left unpaid by your insurance company after 60 days will be billed to you. Although we attempt to verify insurance benefits, your are ultimately responsible for knowing what benefits you have. Payment is due at time of service unless prior payment arrangements have been made. A 50% deposit is required to process all orders. We accept cash, checks and most credit cards. I have read, understand and agree to this financial policy.

____
(signature of patient / responsible party)

Name: ______________________________ Date: ________________

PERSONAL EYE HISTORY (Do you currently have, or have you had problems in the following area?)

	YES	NO
Cataracts	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Retinal Disease	❑	❑
Crossed / Lazy Eye	❑	❑
Eye Injury	❑	❑
Eye Surgery	❑	❑
Other Eye Problems	❑	❑

FAMILY HISTORY (Do any blood relatives currently have, or have had problems in the following area?)

	YES	NO
Cataracts	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Retinal Disease	❑	❑
Crossed / Lazy Eye	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Heart Disease	❑	❑

MEDICAL HISTORY

List any Medications currently taken: ____

____

Allergies to Medications (please list): ____

List any previous surgery, hospitalizations or major illnesses: ______________________________

____

Do you currently, or have you had any problems in the following areas:	YES	NO
General (Fever, Weight loss/gain, Fatigue)	❑	❑
Cardiovascular (High Blood Pressure, High Cholesterol, Heart Attack, Stroke)	❑	❑
Endocrine (Diabetes, Thyroid)	❑	❑
Neurological (Seizures, Migraines, Paralysis)	❑	❑
Respiratory (Asthma, Emphysema, Sarcoidosis)	❑	❑
Allergic/Immunologic (Hayfever, Lupus, Rheumatoid Arthritis, Lyme Disease)	❑	❑
Gastrointestinal (Reflux, Diarrhea, Constipation, Chrohn's disease)	❑	❑
Genitourinary (Frequency Urinary, Kidney Stones, Blood in Urine)	❑	❑
Musculoskeletal (Joint Pain, Muscle Weakness)	❑	❑
Ear Nose Throat (Earaches, Sinus Infection, Nose Bleeds)	❑	❑
Psychiatric (Depression, Anxiety, Memory Loss)	❑	❑
Skin (Acne, Cancer, Warts, Rosacea)	❑	❑
Hematological (Anemia, Bleeding)	❑	❑

SOCIAL HISTORY (Do you use or consume any of the following?)

Use Tobacco products___ packs per day for _____ years	❑	❑
Consume Alcohol ___ drinks per week	❑	❑
Use illegal drugs	❑	❑

Dr.'s Sig. ______________________

Date: ______________________