Please fill out all blanks completely or circle your choice(s) where indicated on the front and back side.

Patient Information

Date: _____

Patient Name (Last): _____

(First Middle): _____

Reason for your visit: _____

Social Security Number:_____-_____-_____

Birthdate:_____/_____/_____ Sex: M F

Home number: (_____ _) _____

Work number: (_____) _____

Cell number: (_____) _____

Preferred phone number: home work cell

Address: _____

City: _____State: _____Zip: _____

Employment status: (Circle one)

employed full-time employed part-time self-employed

not employed retired active military student

Occupation: _____

Employer or school:_____

Marital status:(Circle) single married separated widowed

Spouse/partner's name: _____

Patient Email: _____

Who may we thank for referring you? _____

Responsible Party Information

Social Security Number:_____-_____-_____

Name (Last):_____

(First Middle): _____

Address: _____

City: _____State: _____Zip: _____

Relation to patient:(Circle one)

Self Spouse Child Foster Child Step Child Other

Home number: (_____ _) _____

Work number: (_____) _____

Cell number: (_____) _____

Birthdate:_____/_____/_____ Sex: M F

Email: _____

Policy Information

Insurance Company: _____

ID#: _____ Group#: _____

Group Name: _____

Policy Holder Name (Last): _____

(First Middle): _____

Relation to patient:(Circle one)

Self Spouse Child Foster Child Step Child Other

Birthdate:_____/_____/_____ Sex: M F

Address: _____

City: _____State: _____Zip: _____

Phone number: (_____ _) _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with (name of insurance company) _____ and assign directly to **2001 Vision Center** and its providers all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance, and that fees for services rendered are non-refundable. I authorize the use of my signature on all insurance submissions.

2001 Vision Center and its providers may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, or Guardian _____Date _____

Printed name of signer _____Relation to Patient _____

Social History

Smoking status: (Circle one)
current smoker (heavy/light/occasional)
former smoker never smoked

Ethnicity: (Circle one)
Hispanic or Latino Not Hispanic or Latino
Prefer not to answer

Preferred language: _____

Race: (select all that apply)
American Indian or Alaska Native Asian
Black or African American Native Hawaiian or Pacific Islander
White Other_____ Prefer not to answer

Are you pregnant? Yes No Due date _____

Number of children _____

Alcohol use? Yes No Drug use? Yes No

Eye Health and History

Date of last eye exam: _____

Location of last eye exam?_____

Do you wear? Glasses Contact Lenses

Have you had any of the following?

Bloodshot/red eyes?	Yes	No	Headaches?	Yes	No
Blurry Vision-Far?	Yes	No	Itchy eyes?	Yes	No
Blurry Vision-Near?	Yes	No	Light sensitive?	Yes	No
Burning eyes?	Yes	No	Loss of vision?	Yes	No
Discharge/watering?	Yes	No	Poor Night Vision?	Yes	No
Dizzy Spells?	Yes	No	Seeing Haloes?	Yes	No
Double Vision?	Yes	No	Seeing Flashes?	Yes	No
Eye strain?	Yes	No	Twitching eyelid?	Yes	No
Floaters or spots?	Yes	No	Other:_____		

Have you or anyone in your family had ... ?

	Yourself		Family	
Blindness?	Yes	No	Yes	No
Cataracts?	Yes	No	Yes	No
Poor Color Vision?	Yes	No	Yes	No
Crossed eye(s)?	Yes	No	Yes	No
Eye infection/injury?	Yes	No	Yes	No
Eye surgery?	Yes	No	Yes	No
Glaucoma?	Yes	No	Yes	No
Retinal disease?	Yes	No	Yes	No

Other:_____

Health and Medical History

Primary Care Doctor: _____

Office Name: _____

Date of Last Visit: _____

Should we send a report to your PCP? Yes No

Have you or anyone in your family had ... ?

	Yourself		Family	
AIDS/HIV?	Yes	No	Yes	No
Arthritis?	Yes	No	Yes	No
Artificial Joints?	Yes	No	Yes	No
Asthma?	Yes	No	Yes	No
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
Emphysema?	Yes	No	Yes	No
Epilepsy?	Yes	No	Yes	No
Hay fever?	Yes	No	Yes	No
Heart conditions?	Yes	No	Yes	No
Hepatitis (type____)?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Kidney disease?	Yes	No	Yes	No
Lupus?	Yes	No	Yes	No
Migraines?	Yes	No	Yes	No
Pacemaker?	Yes	No	Yes	No
Shingles?	Yes	No	Yes	No
Skin conditions?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Thyroid condition?	Yes	No	Yes	No

Other:_____

Medications/Allergies

List any medications you are taking (include prescriptions, OTC, vitamins, eye drops, etc). _____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone Number: (_____ _) _____

List any allergies to medications or other substances: _____

_____

_____