PATIENTS INFORMATION

(PLEASE PRINT) DATE: ______________

NAME (LAST) (FIRST) MIDDLE INITAL:

ADDRESS: CITY:

STATE ZIPCODE TELEPHONE TEXT: Y/N

DATE OF BIRTH: / / SEX: M F MARITAL STATUS

OCCUPATION: EMPLOYER:

PRIMARY PHYSICIAN:

CITY: STATE:

INSURANCE INFORMATION

PROVIDE PRIMARY'S INFORMATION BELOW:

NAME: (LAST) FIRST

DATE OF BIRTH: / / LAST 4 OF SSN:

ADDRESS: CITY:

STATE: ZIPCODE: TELEPHONE:

OCCUPATION: EMPLOYER:

VISION INSURENCE CO:

IF APPLICABLE UNIQUE ID #

HOW DID YOU HEAR ABOUT US:

( ) FACEBOOK/SOCIAL MEDIA
( ) EVENTS
( ) NEWSPAPER
( ) MAGAZINE
( ) REFERAL:_____________________
( ) OTHER:________________________________

CONFIDENTAL CASE HISTORY -- REASON FOR EXAM:

( ) New Frames and / or Glasses
( ) Flashing Lights
( ) See Spots/ Floaters
( ) Sun Protection Desired
( ) Blurred Vision (near)
( ) Eyes Tear Excessively
( ) Blurred Vision (distance)
( ) Double Vision
( ) Decreased Night Vision
( ) Difficulty In School
( ) Eyes Tire When Reading
( ) Halos Around Lights
( ) Headaches
( ) Contact Lenses Desired
( ) Eyes Burn and/or Itch
( ) Eye Turn / Lazy Eye
( ) Pain in or Around Eyes
( ) Other ______________________________

INDIVIDUAL HISTORY: PLEASE CHECK ANY THAT APPLY TO YOU

( ) Glaucoma

( ) Pregnant

( ) Hypoglycemia

( ) Blindness

( ) Eye Injury or Infection

( ) Major Surgery

( ) Allergies and /or Hay Fever

( ) Sinus Problems

( ) Heart Problem

( ) High Blood Pressure

( ) Under Physicians Care

( ) Amblyopia (Lazy Eye) R or L ?

( ) Diabetes (How Long?)_______Year(s)

( ) Kidney Problems

( ) Eye Surgery

( ) High Cholesterol

( ) Oral Contraceptives (Birth Control)

( ) Cataracts

( ) Cataract Surgery (date)________________

( ) Presently Taking Medication (please list) ____

____

Do you Have any allergies to medications? ( ) no ( ) yes If yes, explain:__________

____

List any major surgery's and/ or hospitalization you have had:_________________

____

FAMILY HISTORY:

( ) Cataracts

( ) Glaucoma

( ) High Blood Pressure

( ) Blindness

( ) Diabetes

( ) Other:_______________________________________

The Patient understands that:

● I assume full responsibility for all charges incurred.

● Protected health information may be disclosed or use for treatment, payment or health care operations.

● The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

●The Practice reserves the right to change the Notice of Privacy Policies.

● The Patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.

● The Patient may revoke this consent in writing at any time and all future disclosures will then cease.

● The Practice may condition treatment upon the execution of this consent.

● The Practice will keep this information on file for Five Years.

This Consent was signed by : ____

(Patient or Representative) Date: / /