Date: ________________

Name: ______________________________________ Date of Birth: ______________________ SSN: _____________________ Male/Female

Address: ____City: _____________________ State: _______ Zip Code: ____________

Home number: _____________________ Cell number: _____________________ ☐ Okay to leave message ☐ Okay to send text message

Employer: _____________________________ Occupation: _____________________________ Work Number: ________________________

E-mail: ____

Spouse or Guardian: ____ Contact number: ____

Date of Last Eye Exam/Dilation: ______________________ Doctor: ____

Reason for Today's Visit: ____

History

Current Weight: __________ Current Height: __________

Do you use cigarettes/tobaccos? Yes/No Alcohol? Yes/No Other Substances? Yes/No

Average hours on computer/other electronic devices per day: ___________________ Average hours outdoors per week: __________________

Are there any special visual needs for work, home or hobbies? Yes/No If yes please explain: ____

Personal Ocular History

Eye Operation(s)? Yes/No If yes, which type: ____ Date: ___________________

Eye Injury/Injuries? Yes/No If yes, describe type: ____ Date: ___________________

Do you have any of the following conditions?

☐ Blurred Near/Far/Both
☐ Cataracts
☐ Double Vision
☐ Dry Eyes
☐ Excessive Tearing
☐ Eye Pain/Strain
☐ Floaters or Flashes
☐ Glaucoma
☐ Itchy Eyes
☐ Lazy Eye/Eye Turn
☐ Light Sensitivity
☐ Macular Degeneration
☐ Pink/Red Eyes
☐ Retinal Detachment
☐ Other:

Do you wear glasses? No/Yes Near/Far/Both Do you currently wear contact lenses? No/Yes Which brand/Type_________________

Personal Health History *Please mark the appropriate history below:*

Allergic/Immunologic None: ___
☐ Hay Fever
☐ Lupus
☐ Other: _______________

Cardiovascular None: ___
☐ Heart Disease
☐ High Cholesterol
☐ Hypertension
☐ Stroke
☐ Vascular Disease
☐ Other: _______________

Constitutional None: ___
☐ Cancer
☐ Fatigue
☐ Headaches
☐ Migraines
☐ Trauma
☐ Weight Loss
☐ Other: _______________

Ears, Nose, Throat None: ___
☐ Hearing Problems
☐ Upper Respiratory Tract Infection
☐ Other: _______________

Endocrine None: ___
☐ Diabetes
☐ Hormonal Problems
☐ Thyroid Problems
☐ Other: _______________

Gastrointestinal None: ___
☐ Colitis
☐ Digestive Disorder
☐ Ulcer
☐ Other: _______________

Genitourinary None: ___
☐ Kidney Problems
☐ STD
☐ Urinary Tract Infection
☐ Other: _______________

Hematologic/Lymphatic None: ___
☐ Anemia
☐ Clotting Disorder
☐ Leukemia
☐ Other: _______________

Musculoskeletal None: ___
☐ Arthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Other: _______________

Neurological None: ___
☐ Multiple Sclerosis
☐ Seizure Disorder
☐ Other: _______________

Psychiatric None: ___
☐ ADD/ADHD
☐ Anxiety/Panic Disorder
☐ Autism Spectrum
☐ Depression
☐ Schizophrenia
☐ Other: _______________

Respiratory None: ___
☐Asthma
☐ Bronchitis
☐ Emphysema
☐ Other: _______________

Skin/Integumentary None: ___
☐ Eczema
☐ Herpes
☐ Psoriasis
☐Skin Cancer
☐ Other: _______________

Other Conditions:

Please Complete Back of Page

If female, are you currently pregnant? No/Yes Due Date: ______________________________

Please List All Medications you are taking (including over the counter):

____

Are you allergic to any medications No/Yes If yes, please list: ____

Name of Family Doctor: ________________________________ Phone number: __________________ Date of Last Visit: ___________________

Do you have an Advance Directive for Health Care? Yes/No Last Known Tetanus Shot: _____________________________________

In case of an emergency, who do we contact? ____________________________ Relationship: ______________ Phone: ____________________

Family Health/Ocular History *Please mark the appropriate history below and indicate family relation:*

☐Arthritis: _____________________ ☐Diabetes: ____________________ ☐ Macular Degeneration: _______________
☐Asthma: _____________________ ☐Glaucoma: ___________________ ☐Retinal Detachment: _________________
☐Cataract: _____________________ ☐High Blood Pressure: ___________ ☐ Other: ____________________________

Insurance Information *Please circle the appropriate option:*

Vision Insurance: **None**

VSP / Davis / Medicare / Medicaid / Centennial Care / Eyemed / Superior / Presbyterian / Blue Cross Blue Shield / Vision Care Direct

Other: ___________________Vision Insurance ID #: _________________________ Medical Insurance and ID #: _________________________

Responsible party: ____ **Self Spouse Child Other** Member SSN: ________________________

Please indicate if there is a secondary vision/medical insurance: ____________________ Insurance ID #: ________________________________

Responsible party: ____ **Self Spouse Child Other** Member SSN: ________________________

Assignment, Release and Privacy Practice

I give City of Vision EyeCare, P.C.'s my permission to file for insurance benefits and collect fees for services and/or materials which have been provided or ordered on my behalf. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services and products rendered on my behalf or my dependent.

I understand that payment is due at the time services are rendered. Orders will be held for a maximum of **60 Days**. After that time, all orders will be returned and the deposit will be forfeited and not refunded. (There is a $30 service charge on all returned checks.)

I acknowledge that I have been offered a copy of City of Vision, P.C.'s Notice of Privacy Practices. (A paper copy of the Privacy Policy is available upon request.)

____

Patient or Responsible Party Signature **Date**

If patient is over 18: ***The following individuals are authorized to discuss my care and/or release any order materials:***

Name: ____ Relationship: ____

Name: ____ Relationship: ____

Name: ____ Relationship: ____

Doctor Use Only

☐No Change/Changed: _____________________________________ Reviewed by: ______________________ Date: ______________

☐No Change/Changed: _____________________________________ Reviewed by: ______________________ Date: ______________

☐No Change/Changed: _____________________________________ Reviewed by: ______________________ Date: ______________

☐No Change/Changed: _____________________________________ Reviewed by: ______________________ Date: ______________