Patient Information

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/School: _____ Occupation/Grade Level: _____ Work #: _____

E-mail: _____

Spouse or Guardian: _____ Contact number: _____

In case of an emergency, who do we contact? _____ Relationship: _____ Phone: _____

Patient Ocular Lifestyle History

Date of Last Eye Exam/Dilation: _____ Doctor: _____

Reason for Today's Visit: _____

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: _____

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

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

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

☐ Lazy Eye/Eye Turn: _____	☐ Macular Degeneration: _____	☐ Other: _____
☐ Glaucoma: _____	☐ Retinal Detachment: _____	
☐ Blindness: _____	☐ Keratoconus: _____	

Assignment, Release and Privacy Practice

I give City of Vision Eye Care, 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's behalf. I understand that any balances not paid for by insurance either through incorrect information provided or incorrect billing is my responsibility.

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.)

X_____ X_____

Patient or Responsible Party Signature **Date**

The following individuals are authorized to discuss my care and/or release any order materials:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please Complete Back of Page

Patient Current Medical Status

Current Weight: _____ Current Height: _____

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

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

Please List All Medications you are taking (including over the counter): ☐ None

_____

_____

_____

_____

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

_____

Name of Family Doctor: _____ Office Name: _____ Date of Last Visit: _____

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

Patient Past Medical 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
☐ Sleep Apnea
☐ Other: _____

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

Other Conditions:

Family Medical History *Please mark the appropriate history below and indicate family relation:*

Allergic/Immunologic
☐ Lupus

Cardiovascular
☐ Heart Disease
☐ High Cholesterol
☐ Hypertension/High Blood Pressure
☐ Stroke

Endocrine
☐ Diabetes

Hematologic/Lymphatic
☐ Leukemia

Constitutional
☐ Cancer
☐ Migraine

Neurological
☐ Multiple Sclerosis

Other Conditions: