city of vision
eye care

Basic Patient Information

Patient Name: [last-name], [first-name] [middle-initial]

Nickname: [nick-name] || Preferred Pronoun: [pronoun]

Patient Address:

[address] [apt-no]
[city], [state] [zip-code]

Patient Social Security No: [social-security]

Patient Contact Information:

Cell Phone: [cell-phone] || Home Phone: [home-phone]
Email Address: [email-682] || Preferred Method of Contact: [preferred-contact]

Race: [race-field] || Ethnicity: [ethnicity-field]
Preferred Language: [preferred-language]

Patient Birthdate: [patient-bday-month] [patient-bday-day] [patient-bday-year]

Patient Birth Sex: Male Female || **Current Gender Identity:** [gender-identity]

Patient Marital Status: [marital-status]

Patient Occupation/Grade: [occupation] || Employer/School: [employer]

Patient Guardian Information: [parent-guardian]

Billing Address (if different from above)

Billing Address:

[billing-address] [billing-apt-no]
[billing-city], [billing-state] [billing-zip-code]
Billing Phone Information:
Cell: [billing-cell-phone] || Home: [billing-home-phone]

Additional Information

Primary Care Information

Doctor: [primary-care-physician] || Primary Care Clinic: [primary-care-name]
Reason for Visit:[primary-care-reason] || Last Visit: [date-pcvisit]

Insurance Information

Vision Insurance

Vision Insurer Name: [vision-insurer-name]
Vision Insurance ID: [vision-insurer-id] || Vision Insurance Policy Group: [vision-insurer-policy-group]
Primary Vision Policy Holder (if different from patient)

Name of Policy Holder:[vision-policy-holder]
Relationship: Spouse Child Other
Social Security Number: [vision-primary-ssn] || Birthdate: [vision-policy-bday-month] [vision-policy-bday-day] [vision-policy-bday-year]
School/Occupation: [vision-primary-school-occupation]

Address of Policy Holder:
[vision-primary-address] [vision-primary-apt-no]
[vision-primary-city], [vision-primary-state] [vision-primary-zip-code]
Phone Number: [vision-primary-phone]

Primary Medical Insurance

Medical Insurer Name: [medical-insurer-name]
Medical Insurance ID: [medical-insurer-id] || Medical Insurance Policy Group: [medical-insurer-policy-group]
Primary Medical Policy Holder (if different from patient)

Name of Policy Holder:[medical-policy-holder]
Relationship: Spouse Child Other
Social Security Number: [medical-primary-ssn] || Birthdate: [medical-policy-bday-month] [medical-policy-bday-day] [medical-policy-bday-year]
School/Occupation: [medial-primary-school-occupation]

Address of Policy Holder:
[medical-primary-address] [medical-primary-apt-no]
[medical-primary-city], [medical-primary-state] [medical-primary-zip-code]
Phone Number: [medical-primary-phone]

Secondary Medical Insurance

Secondary Medical Insurer Name: [secondary-medical-insurer-name]
Secondary Medical Insurance ID: [secondary-medical-insurer-id] || Secondary Medical Insurance Policy Group: [secondary-medical-insurer-policy-group]
Secondary Medical Policy Holder (if different from patient)

Name of Policy Holder: [medical-secondary-policy-holder]
Relationship: Spouse Child Other
Social Security Number: [medical-secondary-ssn] || Birthdate: [medical-secondary-policy-bday-month] [medical-secondary-policy-bday-day] [medical-secondary-policy-bday-year]
School/Occupation: [medial-secondary-school-occupation]

Address of Policy Holder:
[medical-secondary-address] [medical-secondary-apt-no]
[medical-secondary-city], [medical-secondary-state] [medical-secondary-zip-code]

Phone Number: [medical-secondary-phone]

Appointment Information

Symptoms:[symptom-dropdown]
Reason for Visit:[reason-for-appointment]

Ocular History

Family Ocular History: [family-eye-history]
Last Eye Exam Date: [last-eye-exam] || **Last Eye Exam Location:** [eye-exam-last-doc]
Eye Surgeries or Trauma: [eye-surgeries-trauma]

Contact Lens Wear Information (if applicable)

Does the patient wear contact lenses? [do-you-wear-contacts]
Does the patient need a prescription update? Yes - Service fee is $250 or VSP Copay No - Contact lens prescription is through a different provider or not needed
Contact Lens Solution: [contacts-solution] || **Backup Glasses:** Yes No
Does the patient sleep in their contacts? [contacts-sleep]
How often does the patient replace their contacts? [contacts-replace]

Medical History

Patient History
Known Medical Conditions: [medical-conditions]
Other Conditions Specified: [other-medical-conditions]

Prior Injuries or Surgeries: [injuries-surgeries]
Current Rx Medications: [current-medications]
Known Drug Allergies: [drug-allergies]
Vitamins & OTC Supplements: [current-vitamins]

Family Medical History
Known Family Medical Conditions: [family-medical-conditions]
Other Family Medical Conditions Specified: [family-other]

Coordination of Care
Current Primary Care Physician: [primary-care-physician] || Clinic Name: [primary-care-name]
Last Visit Date: [date-pcvisit] || Last Visit Reason: [primary-care-reason]

Social History

Smoking/Tobacco Status: [smoking-status]
Hobbies: [hobbies]

Patient Occupation: [occupation]

Lifestyle Index

Headaches of any severity during the week: Never Rarely Sometimes Very Often Always
Stiffness while reading or at computer: Never Rarely Sometimes Very Often Always
Discomfort with computer/screen use: Never Rarely Sometimes Very Often Always
Tired/Fatigued eyes: Never Rarely Sometimes Very Often Always
Dry-Eye sensation while working at a computer: Never Rarely Sometimes Very Often Always
Light sensitivity frequency: Never Rarely Sometimes Very Often Always
Dizziness frequency: Never Rarely Sometimes Very Often Always
Reading struggle fFrequency: Never Rarely Sometimes Very Often Always

Retinal Evaluation Question

Does the patient want optomap or dilation: OptoMap - Doctor Recommended. No side effects. (Often covered with $39 copay) Dilation - Side effects include light sensitivity and blurry vision for 6-8 hours.

Terms & Conditions Agreement

Patient has agreed to the terms and conditions: [online-signature] || Date: {DATE j-m-Y}