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 Number: ____________

E-mail: ____ ☐ Okay to e-mail

Spouse or Guardian: ______________________ Contact number: ______________________

Emergency Contact: ______________________ Relationship: ____________ Phone: ______________

Billing & Insurance Information

Primary Vision Insurance: VSP / Davis / Medicare / Medicaid / Superior / Tricare / Presbyterian / Blue Cross Blue Shield / Vision Care Direct

Member SSN/ID #: ______________ Policy Holder Name: __________________ Date of Birth: ____________

Relationship: ________________

Medical Insurance: ______________

Member SSN/ID #: ______________ Policy Holder Name: __________________ Date of Birth: ____________

Relationship: ________________

Patient Ocular Lifestyle History

Date of Last Eye Exam/Dilation: ________________ Doctor/Office: ______________________

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 ☐ 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:

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

☐ Lazy Eye/Eye Turn: ____________

☐ Glaucoma: ________________

☐ Blindness: ________________

☐ Macular Degeneration: ______________

☐ Retinal Detachment: ______________

☐ Keratoconus: ________________

☐ Other: __________

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/ordered on my behalf. I understand that I am financially responsible for all charges, whether or not paid by insurance, for services and products rendered on my behalf or my dependents. I understand that any balances not paid by insurance either through incorrect information provided or incorrect billing is my responsibility. I understand that payment is due at the time services and/or materials are rendered. **I acknowledge that I have been offered a copy of City of Vision Eye Care, PC's Notice of Privacy Practices.** (A paper copy is available upon request.)

x____   ______________

Patient or Responsible Party Signature   **Date**

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):

____

____

____

____

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

Allergic/Immunologic
- ☐ Lupus

Cardiovascular
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Stroke

Endocrine
- ☐ Diabetes

Hematologic/Lymphatic None: ___
- ☐ Leukemia

Constitutional
- ☐ Cancer
- ☐ Migraines

Neurological
- ☐ Multiple Sclerosis

Other Conditions:

If patient is over 18: *Who do you authorize us to release to/discuss your medical information with:*

Name: ____ Relationship: ____________________________________

Name: ____ Relationship: ____________________________________