Patient Information

Patient Name: _____ Date of Birth: _____

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____ Birth Sex: ☐ Male ☐ Female

Phone Number: _____ ☐ Text ☐ Voicemail Email: _____

Occupation/Student Grade: _____ Employer/School: _____

Parent/Guardian, if patient is under 18: _____ Contact Number: _____

Today's Visit

➢ **Reason for visit/vision concerns**	➢ **Do you need a contact lens prescription?**
	☐ Yes, additional fee up to $250 or applicable copay ☐ No

Eye History

Self	Family	Condition	Self	Family	Condition	Eye Surgeries:
☐	☐	Macular Degeneration	☐	☐	Lazy Eye/Crossed Eyes	☐ LASIK/PRK/RK/SMILE
☐	☐	Glaucoma	☐	☐	Blindness	☐ Retinal Hole Repair
☐	☐	Keratoconus	☐	☐	None	☐ Cataract Surgery
☐	☐	Retinal Detachment	☐	☐	Other: _____	☐ Other: _____

Medical History

Prescription Medications	Over-the-Counter Supplements	Drug Allergies

Medical Conditions						Major Surgeries
Self	Family	Condition	Self	Family	Condition	
☐	☐	Diabetes	☐	☐	Asthma / Sleep Apnea / COPD	
☐	☐	High Blood Pressure	☐	☐	Autism Spectrum or ADD	
☐	☐	Heart Disease	☐	☐	Cancer	
☐	☐	Rheumatological Disease	☐	☐	Other: _____	

Primary Care Physician: _____ Clinic Name: _____

Assignment, Release, and Privacy Practice

By signing below, I give City of Vision Eye Care, P.C. my permission to file for insurance benefits and collect fees for services and/or materials that have been provided/ordered on my behalf. I understand that I am financially responsible for all charges should my insurance deny coverage. 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.

_____ _____

Patient or Responsible Party Signature **Date**