Welcome to Vision Care Center, PC

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Master ☐ Male ☐ Female

First Name ______ MI ___ Last Name ______ Date of Birth ______ Social Security Number ______

Street Address ______ City ______ State Zip ______ Email Address ______

Home Phone ______ Work Phone ______ Spouse or Parent(s) Name ______ Person Responsible for Account ______

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

Family Doctor (PCP) ______ PCP Phone ______

School Name If Applicable ______ ☐ **Mr.** ☐ **Ms.** Teacher's Name ______ Grade ______

Employer Name If Applicable ______ Employer Phone ______ Emergency Contact ______ Contact Phone ______

How were you refered to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) ______

☐ Insurance Listing ☐ Drive by ☐ Other ______ ☐ Doctor (Please Name) ______

Insurance Information

Company: ______ ID# ______ Group# ______

Subscriber's Name: ______ Subscriber's Dob: ______

Subscriber's Employer: ______

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

If there is a secondary insurance, please make sure the receptionist has that information on file.

Financial Responsibility

I understand that all copays and non-covered services will be collected for at the time of service. If Vision Care Center is filing insurance on my behalf, I authorize the payment be made directly Vision Care Center. I understand that any balance that insurance does not pay, for any reason, is my responsibility and will be paid promptly. A service charge of $30 will be added to all returned checks and if the account is turned over to a collection agency, I understand I will be responsible for all fees associated with the collection of my account.

Authorization to Release Medical Information

I authorize Vision Care Center to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing.

Private Health Information

My signature below acknowledges that I was provided the opportunity to receive/review a copy of Vision Care Center's Privacy Policy Notice.

Patient/Guardian Signature ______ Date ______

A copy of this form will be transferred to an electronic format and will be considered as valid as the original.

Name

Vision Care Center, PC
PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician | City | State | Zip | Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician | City | State | Zip | Phone

HEALTH HISTORY

What is the main reason for today's exam ? ____________ When was your last exam ? ________

When was your last health exam ? ________

Past Illnesses or Injuries: ________

Past Surgeries: ________

Current Medications: ________

Current Eye Drops: ________

Medicines that cause reactions or sensitivities: ________

Specific Allergies: ________

EYE HISTORY

Condition		Condition		Condition	
Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Condition		Condition		Condition	
Fever	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Weight Loss	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Thyroid, Diabetes	○ Yes ○ No
Other Symptoms	○ Yes ○ No	Kidney	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Allergic	○ Yes ○ No
Cardiovascular (high blood pressure etc.)	○ Yes ○ No	Skin	○ Yes ○ No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	○ Yes ○ No		

FAMILY HISTORY

Condition		Condition		Condition	
Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

Name

Vision Care Center, PC

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : ______________ Years ________ Employer ______________

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? ______ Distance from Computer? ______

Do you drive? ○ Yes ○ No Mileage to work each way? ______

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since ________

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No ______________

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? ______________

Do you currently wear contact lenses? ○ Yes ○ No Since ______________

Type and brand of contact lenses ______________ Today's wearing time ? ______

How many hours/day ? ______ How many days/week ? ______

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	____	____	Distance Vision	____	____	Near Vision	____	____

What Solutions do you use? Cleaner ______________ Disinfectant ______________ Enzyme ______________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : ______________