Vision Health
CENTER, P.C.

Contact Information

Today's date: _____

Patient name: _____ Date of birth: _____

Occupation/School: _____ Employer/Grade: _____

Home phone: _____ □ Preferred contact

Work phone: _____ □ Preferred contact

Mobile phone: _____ □ Preferred contact □ Text □ Voice

Email address: _____ □ US mail preferred

May we leave messages with information about appointments, orders, or test results at your preferred contact number? □ Yes □ No

Persons to whom we may release or discuss your medical information (spouse, parents, etc.):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

How did you hear about our office?

□ Friend or relative: _____ □ Health care provider:_____

□ Insurance provider □ Phone book □ Facebook □ Website:_____

□ Newspaper:_____ □ Radio:_____ □ Community event:_____

Signatures on file

□ Copies of Vision Health Center, P.C.'s "Notice of Privacy Practices" are available at www.visionhealthcenter.net and both office locations. My signature acknowledges I have either received or accepted adequate access to a copy of the "Notice."

□ I request that the payment of authorized insurance or Medicare benefits be made either to me, or on my behalf to Vision Health Center, P.C., for medical services furnished to me by Drs. Sloan or Smith. My signature authorizes release to my insurance company any medical information necessary to determine payment for related services.

Consent for use of eye drops for dependents/minors:

□ As part of the comprehensive eye health examination, eye drops for the purpose of temporary anesthesia and/or pupillary dilation will be instilled. Blurred vision at near is a customary side effect. Dilation typically lasts for three to four hours; while some stronger dilating agents can last for more than 24 hours. My signature indicates consent for the use of these drops during examination today and on subsequent exams.

Patient (or Guardian) Signature: _____

Office Use Only: Intake Scanned Intake Entered: 1 2 Med List Scanned Ins Cards Scanned E Encounter E Chart Paper Chart

Ocular and Medical History

Today's date: _____

Patient name: _____ Date of birth: _____

Primary physician: _____

Location: _____

Last eye exam: □ Here □ Another clinic: _____ When: _____

Are you interested in:

□ Contact lenses □ Computer glasses □ Sunglasses □ Safety glasses □ Sports glasses □ LASIK

Are you experiencing:

□ Blurred vision □ Double vision □ Tired eyes □ Floating spots □ Flashes of light □ Eye infections
□ Dry eyes □ Red eyes □ Burning eyes □ Itching eyes □ Watery eyes □ _____

Contact Lens Wearers: What do you like about your contacts: _____ Dislike: _____

Brand/type: _____ Replacement frequency: _____ Cleaning solution: _____

Have you been diagnosed with:

□ Cancer	□ Fatigue	□ Developmental disability		
□ Hearing loss	□ Sinusitis	□ Dry mouth		
□ Headache	□ Migraine	□ Seizures □ MS	□ Tumor	□ Stroke
□ Autism	□ Depression	□ Anxiety	□ Bipolar	
□ High blood pressure	□ Cardiovascular disease	□ Congestive heart disease		
□ Asthma	□ Sleep apnea	□ COPD		
□ Acid reflux	□ Ulcer	□ Celiac	□ Crohn's	
□ Kidney disease	□ Herpes	□ Chlamydia	□ Gonorrhea	□ HIV
□ Osteoporosis	□ Fibromyalgia	□ Ankylosing spondylitis	□ Arthritis	□ Gout
□ Rosacea	□ Eczema	□ Psoriasis	□ Cold sores	□ Shingles
□ Type 1 diabetes	□ Type 2 diabetes	□ Thyroid dysfunction		
□ Elevated cholesterol	□ Anemia			
□ Rheumatoid arthritis	□ Lupus	□ Sjogren's		
□ Cataract	□ Retinal detachment	□ Macular degeneration	□ Glaucoma	□ Lazy eye

□ Eye injury: _____ □ Eye surgery: _____

Currently Pregnant or Nursing □ Yes □ No **Do you drive?** □ Yes □ No

Social History Alcohol use: □ No □ Yes amount:_____

Tobacco use: □ No □ Yes status: □ current □ former □ never type: _____

Medications: *(Provide name and dosage of all Rx and over-the-counter medications including vitamins and eye drops)*

_____

_____

_____

_____

Drug Allergies □ None □_____

Environmental Allergies □ None □ Latex □_____

Family Medical and Ocular History

□ Diabetes	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ High Blood Pressure	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Heart Disease	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Cancer	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Cataracts	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Glaucoma	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Macular Degeneration	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Retinal Detachment	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Lazy Eye	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ _____	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____